

Michigan Cancer Surveillance Program

Abstract Plus User Manual Version 5.0

Effective for cases diagnosed ON or PRIOR to December 31, 2013



Registry Plus Software for Michigan Registries

(Based on Abstract Plus Version 3.3.1.2, NAACCR v13.0)

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Chapter 1: Introduction

Overall Learning Objectives

These are the overall learning objectives of the MCSP Abstract Plus User Manual for abstractors:

- Learn how to Log in into Abstract Plus 3.3.1.2, NAACCR version 13.0
- Learn about the Abstract Plus menu items
- Become familiar with the basic steps for abstracting using Abstract Plus
- Learn how to begin abstracting by starting a new abstract, opening an existing abstract, or copying an existing abstract
- Become familiar with the abstracting features of Abstract Plus, including entering text fields, coding histologic type, and coding and deriving Collaborative Staging fields
- Learn about the Abstract Plus editing features and how to correct edit errors
- Learn how to print abstracts
- Learn how to export abstracts out of Abstract Plus
- Become familiar with Abstract Plus Utilities
- View, print, and save available abstract reports, and run custom reports

Overview of the Abstract Plus Abstractor User Manual v5.0

The Abstract Plus Abstractor User Manual provides you with the information to understand and use the abstracting features of Abstract Plus. This manual describes the functions available to the Abstractor. The major sections include logging in to Abstract Plus, abstracting information, editing abstracted information, completing abstracts, exporting abstracts, using utilities, and viewing abstract reports. Also, each chapter contains questions that test your knowledge of the Abstract Plus abstracting features and activities that allow you to practice your new skills on your own.



The Michigan cancer reporting requirements are included in the *MCSP Cancer Program Manual*, which is available at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.



Abstract Plus v3.3.1.2, NAACCR v13.0 is effective for cases diagnosed ON or PRIOR to December 31, 2013. **Cases diagnosed 2013 or earlier must** be submitted to the MCSP in NAACCR format version 13.0.

Abstract Plus Features

Abstract Plus is a free-of-charge, cancer data collection tool developed by the Centers for Disease Control and Prevention (CDC) that supports two main functions: abstracting and auditing. The application can be customized by central cancer registries to be used centrally, as well as for distribution to and use by hospitals and other reporting sources. Although the product is not designed to include all functionality needed in an American College of Surgeons (ACoS)-approved hospital cancer registry, it is suitable for reporting to central registries from non-registry hospitals, clinics, laboratories, and other sources for cancer incident reports. The program can also be used for special projects and start-up registries.

The abstracting capability of Abstract Plus is used to summarize medical records into an electronic report of cancer diagnosis and treatment by abstractors or anyone working with cancer data. Abstract Plus supports the abstraction of all data items in national standard data sets, including all text fields, as well as any state-specific data items. The output of Abstract Plus is an electronic abstract in the format of the North American Association of Central Cancer Registries (NAACCR) data exchange layout.

Abstracts entered into Abstract Plus are validated by customizable edits, allowing for interactive error correction while abstracting. Abstract Plus includes Registry Plus Online Help, a collection of standard coding manuals that are cross-referenced, indexed, and context-linked to minimize the need for reference to printed manuals during abstracting.

Abstract Plus version 3.3 has been entirely reprogrammed using .NET technology. The application has a new, more user-friendly abstracting interface. New direct grid entry of coded values allows for a more streamlined abstracting experience, as well as easier viewing of text fields, online help, and edit errors.

Abstract Plus also has enhanced security features. All records are saved in Microsoft Access or SQL server databases, and all tables are password protected and encrypted using Microsoft functions. All users must have a User ID and password to access the abstracting features of the application, and access to administrative and auditor functions requires the entry of special restricted passwords. A security challenge question feature is also included in case a user forgets his or her password, which enables the user to securely reset their password without administrator intervention.



For Michigan, the *MCSP Abstract Plus User Manual* overrides the Generic Registry Plus Online Help Abstract Plus Users Guide.

Abstract Plus User Roles

Abstract Plus users consist of abstractors, central cancer registrars, and other individuals or groups who work with cancer data. Abstract Plus includes 3 types of users, or roles:

User	Description
Abstractor/ General User	<p>The Abstractor or general user manages data entry and has access to all of the abstracting features of the program.</p> <p>Abstractors can add new abstracts, edit existing abstracts, copy, print, and delete abstracts, and can import and export abstracts in NAACCR file format. Abstractors can also view available reports and update their password and personal security challenge questions.</p> <p>All Abstractors must have a user account, and log in to the application using a User ID and password.</p>
Auditor	<p>The Auditor manages audit entry and reporting and has access to all of the abstracting features of the program described above for the general user; however, Auditors also have access to all of the auditing features of the program.</p> <p>Auditors can open and close audits, and perform casefinding, reabstraction, and recoding audits (including pre- and post-reconciliation tasks), and run available audit reports. Auditors can also export newly identified tumors in NAACCR file format from casefinding efforts, and can export completed reabstraction and recoding audits.</p> <p>All Auditors must have a general user account, and log in to the application using a User ID and password. Auditors access auditing functions using a special Auditor password.</p>
Administrator	<p>The Administrator manages the setup of the program and has access to all of the abstracting features of the program described above for the general user and all of the auditing features available to the Auditor; however Administrators have access to additional administrative features of the program. They can perform administrative functions such as managing the Administrator password, creating and modifying general user accounts, specifying application preferences, creating and managing abstracting display types, and creating and managing audit display types, discrepancy codes and databases.</p> <p>All Administrators must have a general user account, and log in to the application using a User ID and password. Administrators access administrative functions using a special Administrator password. Entry of the Administrator password also allows access to all auditing functions (i.e., entry of the Auditor password is not required for Administrators).</p>

**Note**

The Auditor features of the program have been temporarily disabled and will not be available for use in Abstract Plus v3.3.1.2, NAACCR v13.0. Description of the auditor features is for informational purposes only.

System Requirements

Abstract Plus is programmed for the Microsoft Windows 32-bit environment installed on an Intel Pentium or Pentium-compatible computer. The minimum hardware requirements are the same as those of the Microsoft Windows operating system used. Additional system requirements include:

System Component	Client Computer
RAM	512 MB or more
Hard Disk	200 MB of free space
OS	Windows XP or later
.NET Framework	Version 4.0 or later

Downloading and Installing Abstract Plus

To Install or Re-install (upgrade) Abstract Plus version 3.3.1.2, NAACCR format version 13.0, you must follow the installation instructions as provided by the MCSP. If you need a copy of the installations instructions or technical support, contact Terry McTaggart at McTaggartT1@michigan.gov or (517) 335-9624.



If you have a prior version of Abstract Plus installed on your computer, and would like to upgrade to Abstract Plus version 3.3.1.2 there is no automatic upgrade available. **Do NOT uninstall your current version, as you will need to export ALL abstracts out of your current version of Abstract Plus.** To install or upgrade to Abstract Plus v3.3.1.2, you must complete the installation instructions provided by the MCSP.



You must have administrative privileges to your computer in order to install Abstract Plus. Contact your system administrator to install the program if you do not have administrative privileges.

Launching Abstract Plus

Once installed, you can launch Abstract Plus:

- From the Start menu, select **All Programs, Registry Plus, Abstract Plus**, and then **Abstract Plus**.

User Support

Technical Support

For technical support, contact Terry McTaggart at McTaggartT1@michigan.gov or (517) 335-9624.

Abstracting Support

For abstracting support, contact MCSP field representative Jetty Alverson at alversong@michigan.gov or (517) 335-8855.

MCSP Cancer Program Manual

The Michigan Cancer Surveillance Program (MCSP) Cancer Program Manual provides information on the administrative rules on cancer reporting and Michigan reporting facility responsibilities, as well as, detailed instructions on coding, e.g., preparation of the cancer report form, follow-up work on reported cases, reportable conditions, ambiguous terminology, case finding procedures and components of good reporting. A copy of the MCSP Cancer Program Manual is available at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html

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Chapter 2: Abstract Plus General User Basics

Learning Objectives

In this chapter, you will learn to:

- Create your own user account upon initial access to the program
- How to address first-time log in and routine log in to Abstract Plus as an Abstractor/general user
- Familiarize yourself with the Abstract Plus main window and identify Abstract Plus abstracting menu options
- Change your general user password
- Reset your password if forgotten, by answering your security challenge questions
- Update your security challenge questions and answers after initial set up
- Exit Abstract Plus and use the Backup option
- Use the Restore option to restore your abstracts database if corrupted

Overview

This chapter covers the basics of logging in to and out of Abstract Plus. It includes a description of the process by which a user account is generated, how to log into Abstract Plus for the first time and how to address the security challenge questions presented upon initial log in, how to log in to Abstract Plus routinely using a user ID and password, how to maintain your general user password, how to check for software updates over the Internet and view your software update history, how to exit the application and use the Backup feature, and how to use the Restore feature to restore a corrupted abstracts database.

Logging In

After installing Abstract Plus, upon initial launch of the program, you will be prompted to create a new user account. You will then need to log in using the new login information you entered along with an initial password of **Welcome1**, change your password, and then answer security or “challenge” questions. Your answers to these questions will be used to validate your identity if you forget your Abstract Plus password. If you forget your password, Abstract Plus will ask you for the answers you provided to these security questions and then allow you to reset your password if the questions are answered correctly.

The creation of a user account is enabled for the general user **only** upon initial launch of the program. If other users already exist in your Abstract Plus application (i.e. the program has already been launched and user account(s) created), you will need to contact your Administrator to create a user account for you.

When logged in with your own user ID and password, you are recorded as the abstractor when conducting general abstracting or auditing tasks (unless your Administrator has modified this system option). This information can be used as selection criteria for reports and exports, and can also be used for general tracking purposes to associate abstractors with their specific abstracts, and auditors with the audits that they have conducted.

Creating a User Account upon Initial Access and First-Time Log In

After installing Abstract Plus, if you are the first person to launch the program, you will be prompted to create a new user account. You will then be prompted to log in to Abstract Plus using your newly-created User ID and an initial password of **Welcome1**.

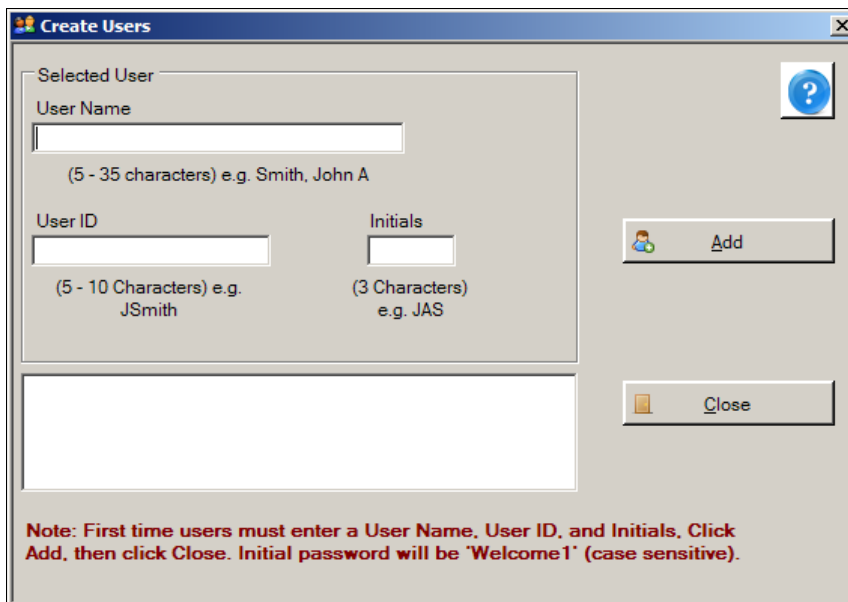


If other users already exist in your Abstract Plus application (i.e. the program has already been launched and user account(s) created), you will need to contact your Administrator to create a user account for you and obtain your User ID.

To create a new user account upon initial launch of the program, and log in to the application for the first time complete these steps:

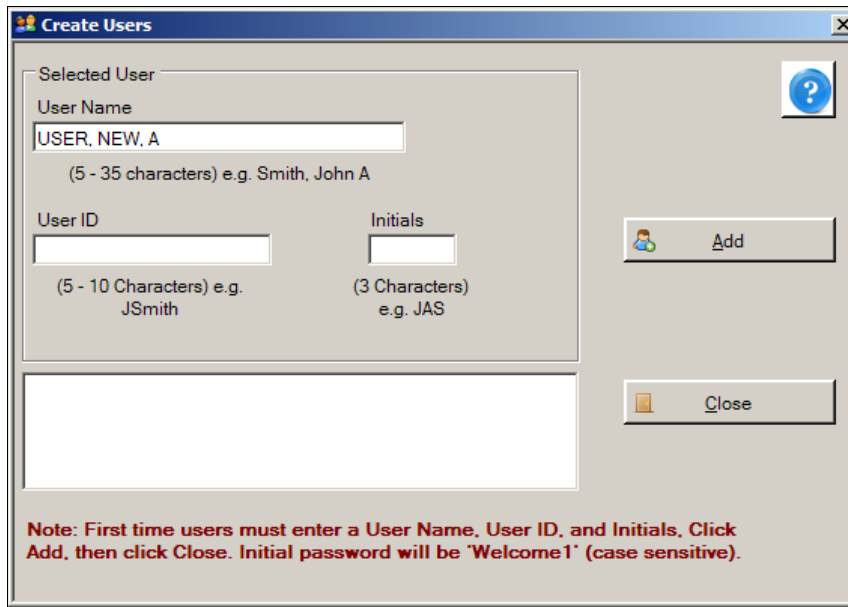
1. To launch the program, from the Start menu, select **All Programs, Registry Plus, Abstract Plus**, and then **Abstract Plus**.

Result: The **Create Users** window opens.



If your Administrator has already provided you with a User ID, go directly to [step7](#).

2. Enter your full name in the **User Name** field. The format for name entry is last name, and then first name and middle initial, e.g., Smith, John A. In the example shown, the user name being entered has the last name USER, first name NEW, and middle initial A.



Create Users

Selected User

User Name
USER, NEW, A
(5 - 35 characters) e.g. Smith, John A

User ID
(5 - 10 Characters) e.g. JSmith

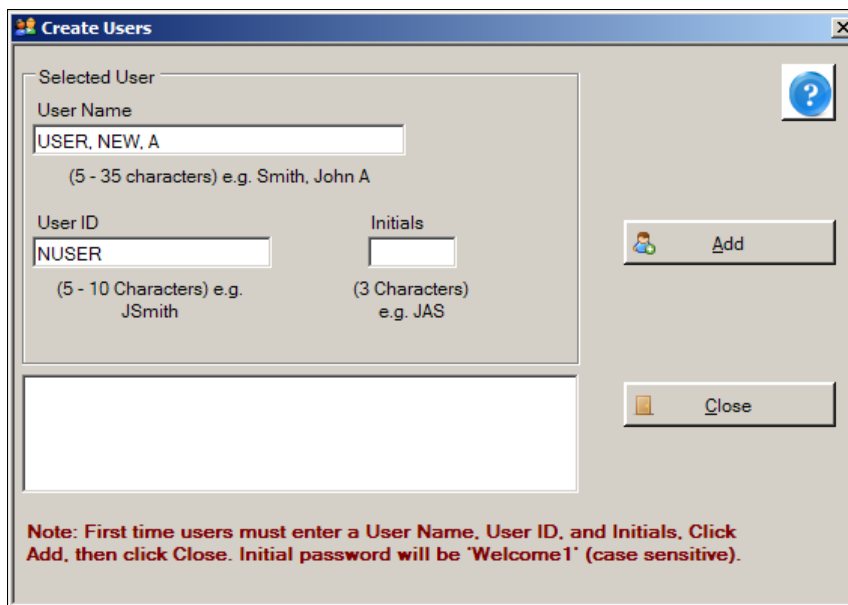
Initials
(3 Characters) e.g. JAS

Add

Close

Note: First time users must enter a User Name, User ID, and Initials, Click Add, then click Close. Initial password will be 'Welcome1' (case sensitive).

3. Enter a **User ID** in the **User ID** field. User IDs can only be characters, and are 5-10 characters in length. In the future, you will enter your User ID when logging in to Abstract Plus. In the example shown, the User ID being entered is NUSER.



Create Users

Selected User

User Name
USER, NEW, A
(5 - 35 characters) e.g. Smith, John A

User ID
NUSER
(5 - 10 Characters) e.g. JSmith

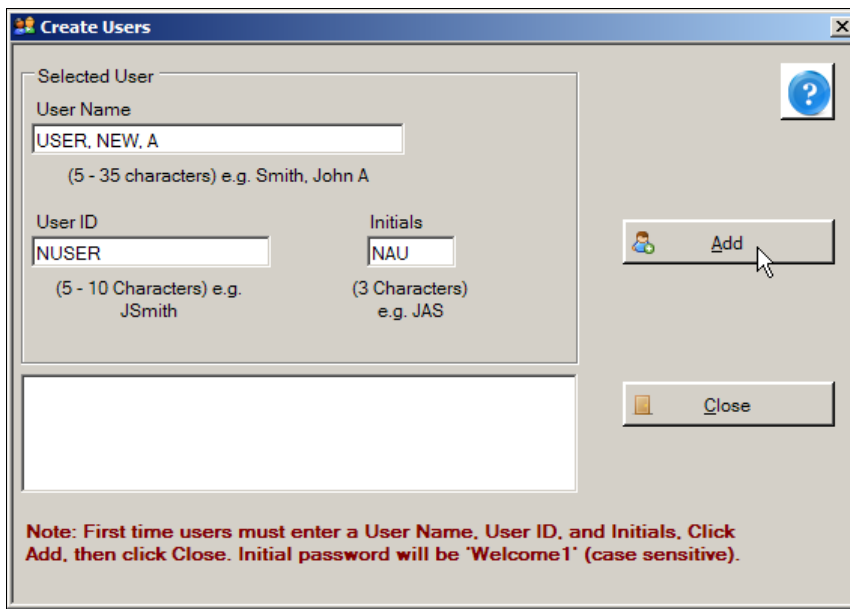
Initials
(3 Characters) e.g. JAS

Add

Close

Note: First time users must enter a User Name, User ID, and Initials, Click Add, then click Close. Initial password will be 'Welcome1' (case sensitive).

4. Enter your initials in the **Initials** field. Your initials will be displayed on the main Abstract Plus window to indicate when you are logged in to the application, and may be automatically recorded in the Abstracted By field when abstracting abstracts or conducting audits if this application preference is enabled by your Abstract Plus Administrator. This information is recorded in order to associate abstractors with the abstracts they have generated, and auditors with the audits that they have conducted. In the example shown, the initials entered are NAU.



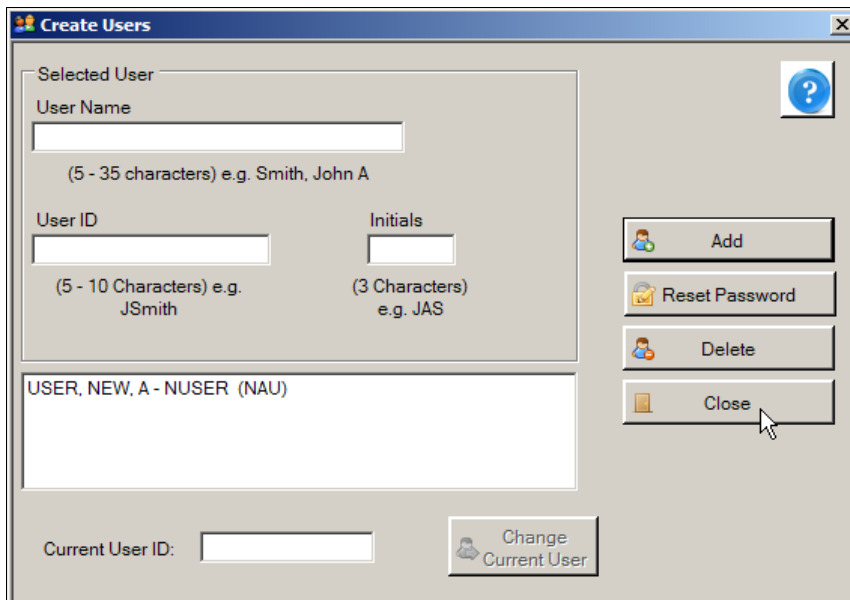
The 'Create Users' window displays a form for adding a new user. The 'Selected User' section contains the following fields:

- User Name:** (5 - 35 characters) e.g. Smith, John A
- User ID:** (5 - 10 Characters) e.g. JSmith
- Initials:** (3 Characters) e.g. JAS

Below these fields is a large empty text area. To the right of the form are two buttons: 'Add' (with a person icon) and 'Close' (with a door icon). A mouse cursor is clicking the 'Add' button. A blue question mark icon is in the top right corner. A red note at the bottom states: "Note: First time users must enter a User Name, User ID, and Initials, Click Add, then click Close. Initial password will be 'Welcome1' (case sensitive)."

5. Click **Add**.

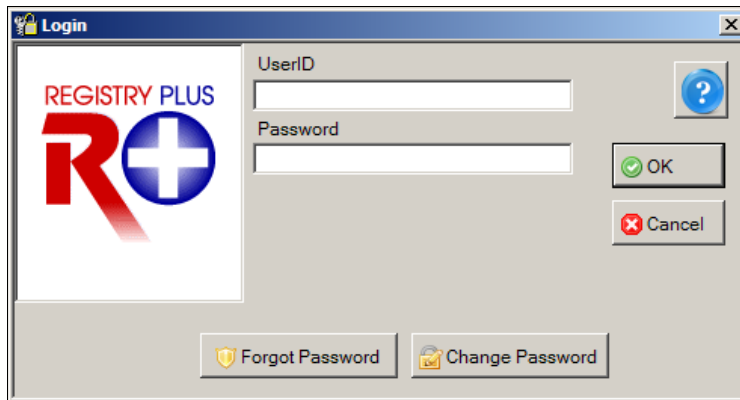
Result: The system adds the new user account to the users list.



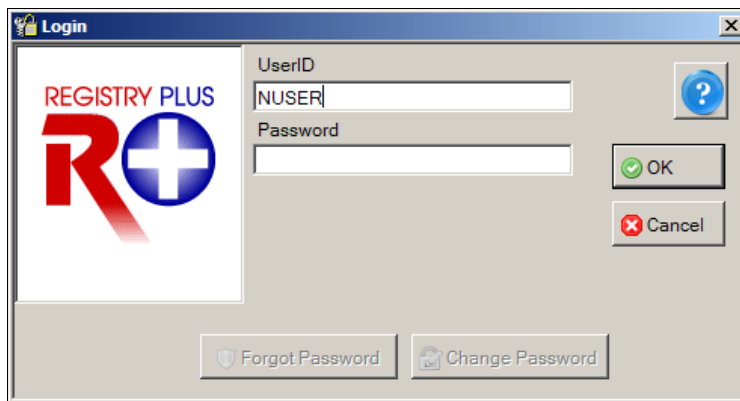
The 'Create Users' window now shows the user 'USER, NEW, A - NUSER (NAU)' in the large text area. The 'Add' button is disabled. The 'Reset Password' button (with a key icon) is now visible. The 'Delete' button (with a person icon) and 'Close' button (with a door icon) are also visible. A mouse cursor is clicking the 'Close' button. The 'Current User ID' field at the bottom left is empty, and the 'Change Current User' button (with a person icon) is visible next to it. The red note is no longer present.

6. Click **Close**.

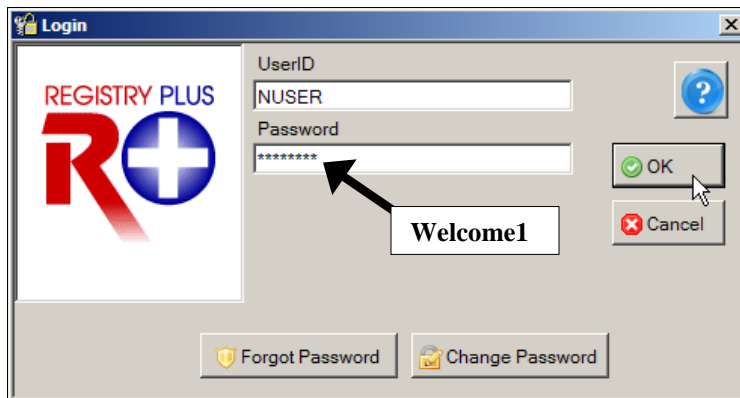
Result: The **Login** window opens.



7. Enter your **User ID** in the **User ID** field. In the example shown, the User ID of NUSER is being entered.



8. Enter the default initial password of **Welcome1** in the **Password** field.

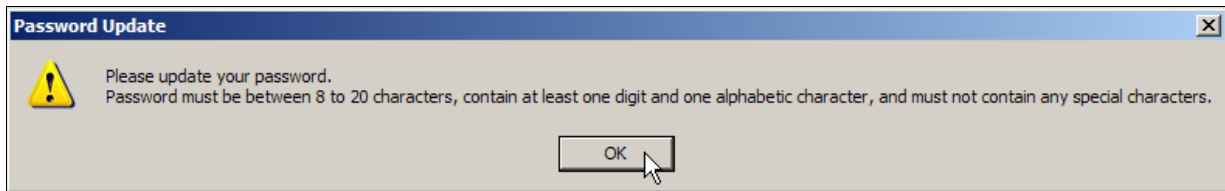


Note

When entering your password, asterisks will be displayed rather than your password for added security. **Note that passwords are case sensitive.**

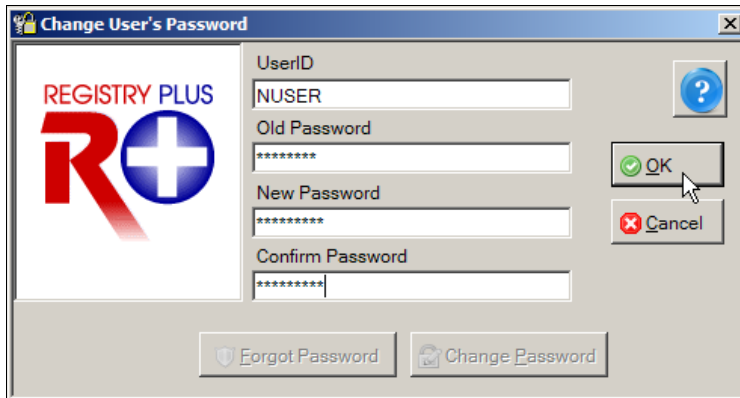
9. Click **OK**.

Result: A **Password Update** message is issued that lets you know you need to change your password. This occurs upon initial log in only. When changing your password, you must change it to a password that meets the password requirements set by your Abstract Plus Administrator.



10. Click **OK**.

Result: The Change User's Password window opens, displaying your User ID and Old Password (which is **Welcome1** at this point).



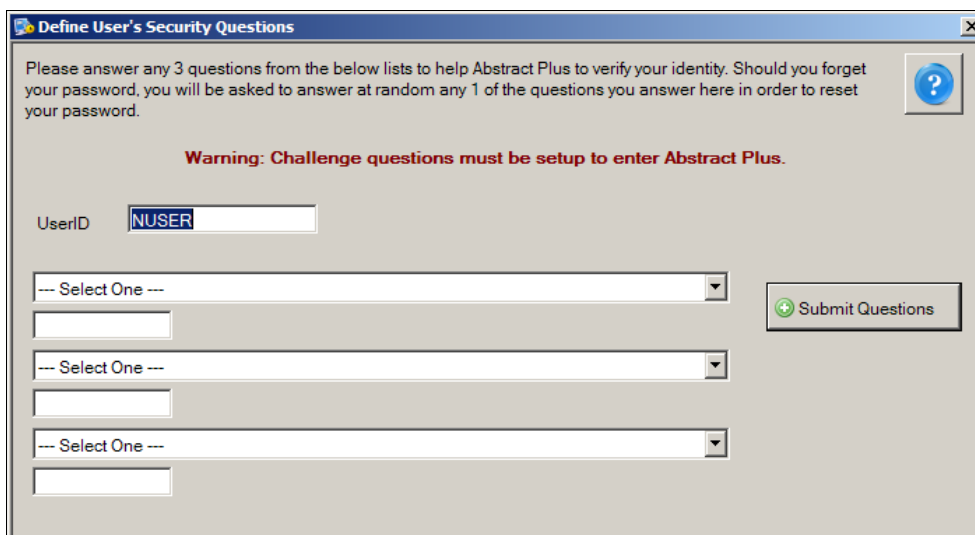
11. Enter a new password in both the **New Password** and **Confirm Password** boxes, and click **OK**. You must type the same new password in both boxes.



Note

If your Administrator has made no changes, by default, your new password must be between 8 and 20 characters, contain at least one digit and one alphabetical character, and must not contain any special characters.

Result: The **Define User's Security Questions** window opens, with your User ID displayed.



To complete your initial log in to Abstract Plus, you are required to select the specified number of security questions and answer them. The number of questions you will need

to select and answer will depend on the number of security questions specified by your Abstract Plus Administrator when setting up Abstract Plus. Your answers to these questions will be used to validate your identity if you forget your general user Abstract Plus password. If you forget your password, Abstract Plus will ask you for the answers you provided to your chosen security questions, and then allow you to reset your password if the questions are answered correctly. If you forget both your password and your answers to your selected security questions, you will need to have your Abstract Plus Administrator reset your password.

12. Select a **question** from the first drop-down list and enter your **answer** in the box below the question.

Define User's Security Questions

Please answer any 3 questions from the below lists to help Abstract Plus to verify your identity. Should you forget your password, you will be asked to answer at random any 1 of the questions you answer here in order to reset your password.

Warning: Challenge questions must be setup to enter Abstract Plus.

UserID:

--- Select One ---

- How many children do you have?
- How many siblings do you have?
- How old were you at your wedding? (Enter age as digits.)
- In what city did you honeymoon? (Enter full name of city only)
- In what city is your vacation home?
- In what city was your father born in? (Enter full name of city only)
- In what city was your high school?

13. Continue selecting questions and answering them until each question is answered.

Define User's Security Questions

Please answer any 3 questions from the below lists to help Abstract Plus to verify your identity. Should you forget your password, you will be asked to answer at random any 1 of the questions you answer here in order to reset your password.

Warning: Challenge questions must be setup to enter Abstract Plus.

UserID:

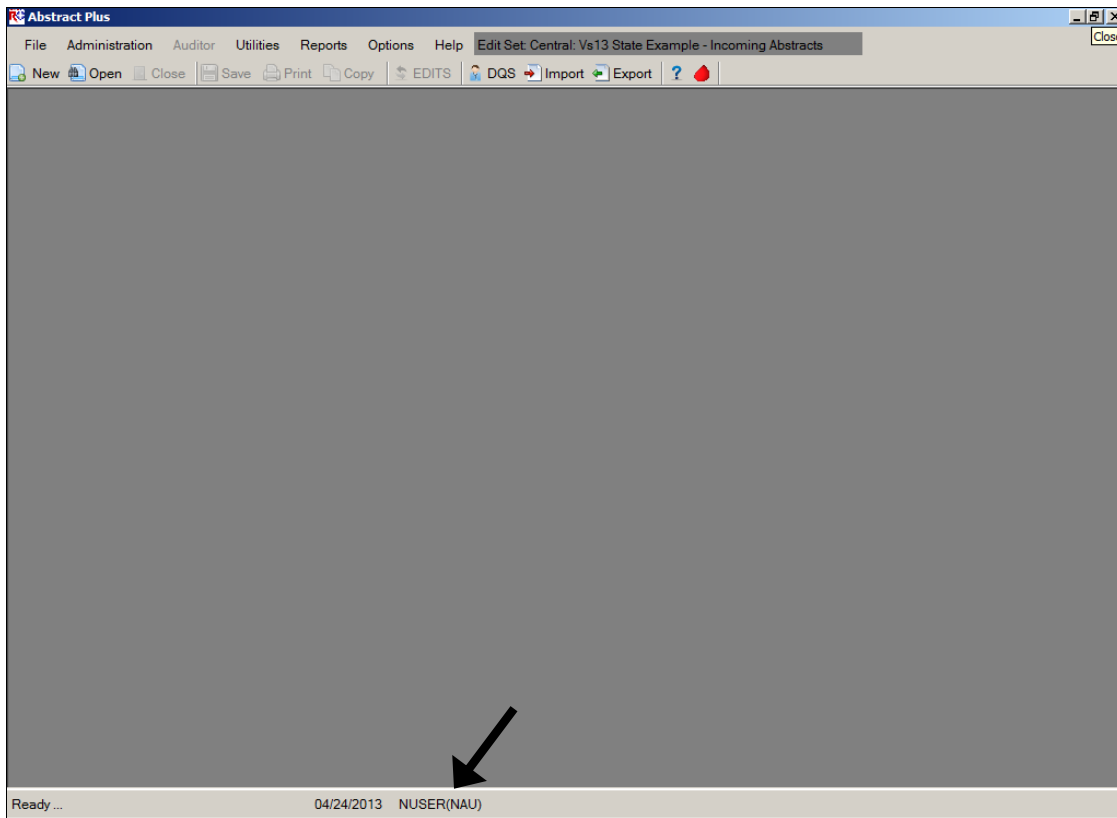
How many children do you have?

How many siblings do you have?

How old were you at your wedding? (Enter age as digits.)

14. Once all questions are selected and answers entered, click **Submit Questions**.

Result: The Abstract Plus **main window** opens, with you logged in as a general user. Note that your User ID is displayed at the bottom of the window.



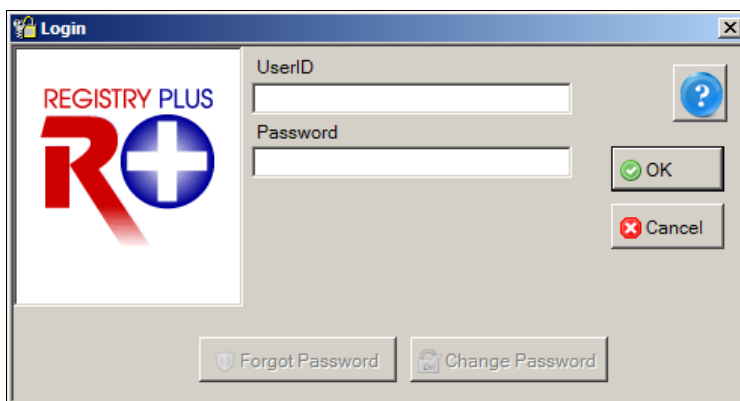
Routine Log In

After installation and initial log in to Abstract Plus, you will have a User ID and password for routine log in to your Abstract Plus general user account.

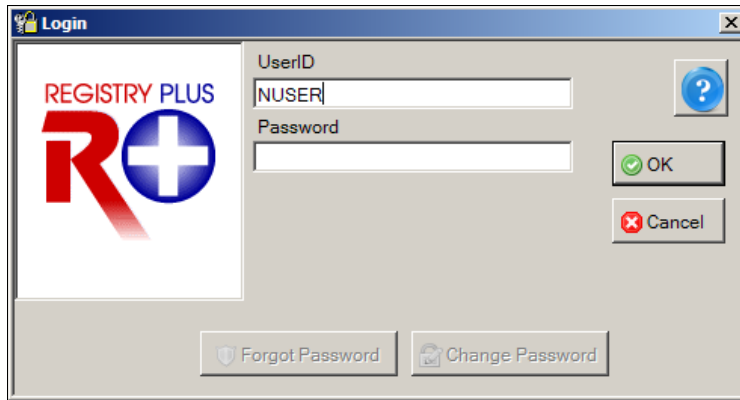
For routine log in to Abstract Plus, complete these steps:

1. To launch the program, from the Start menu, select **All Programs, Registry Plus, Abstract Plus**, and then **Abstract Plus**.

Result: The **Login** window opens.



2. Enter your **User ID** in the **User ID** box. In the example shown, the User ID being entered is NUSER.

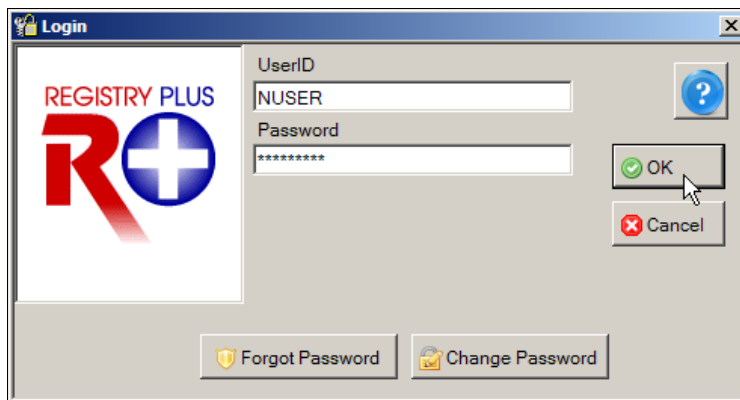


3. Enter your **password** in the **Password** box, and Click **OK**.

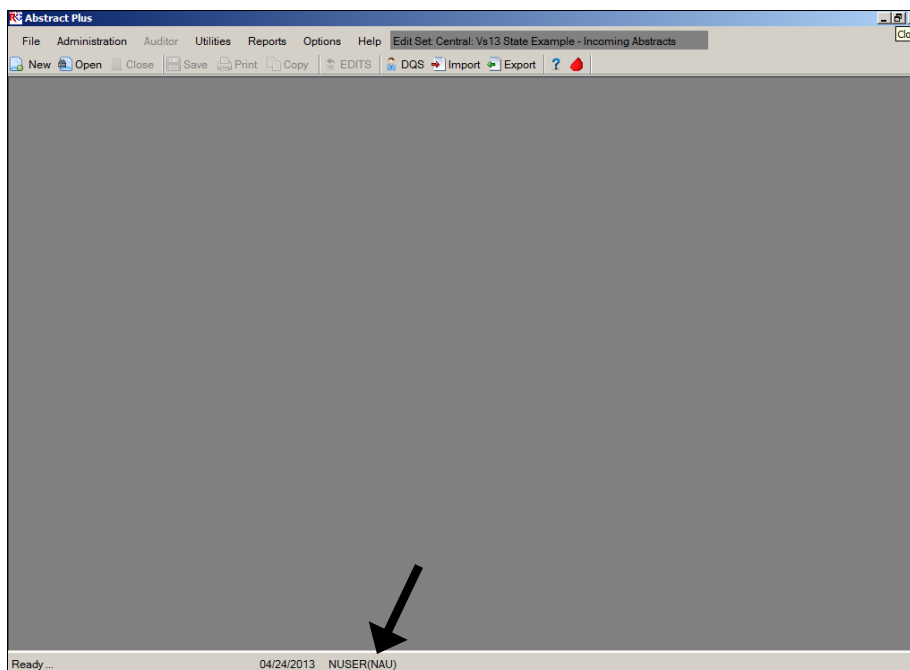


Note

When entering your password, asterisks will be displayed rather than your password for added security. Note that passwords are case sensitive.



Result: The Abstract Plus **main window** opens, with you logged in as a general user. Note that your User ID is displayed at the bottom of the window.



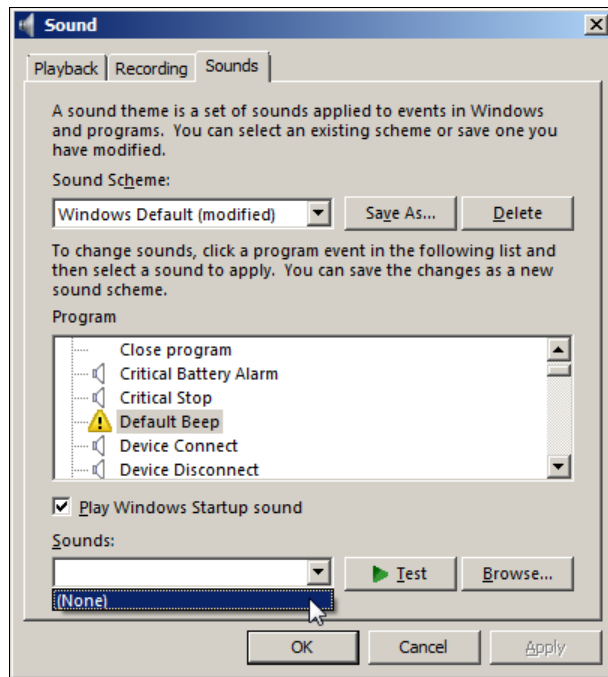
The Abstract Plus Main Window

The Abstract Plus main window provides access to all of the application's features. Your User ID is displayed at the bottom of the window, and important system messages are displayed in the lower left-hand corner of the window. The default edit set is displayed in the upper right-hand corner of the window. When logged in as an Abstractor, you will automatically have access to all of the application's abstracting features via the main menu items. Some menu options are also available as buttons in the toolbar as shown below. Access to Administrator and Auditor functions require entry of special passwords.

By default, Microsoft comes with sound effect features. One of those features is a “beep” feedback sound in response to pressing the tab or enter key. If you do not like these sounds being issued as you use Abstract Plus, you can turn them off by going to Start→Control Panel→Sound→Sounds Tab→select Default Beep→select None from the Sounds pull-down menu→Click OK.

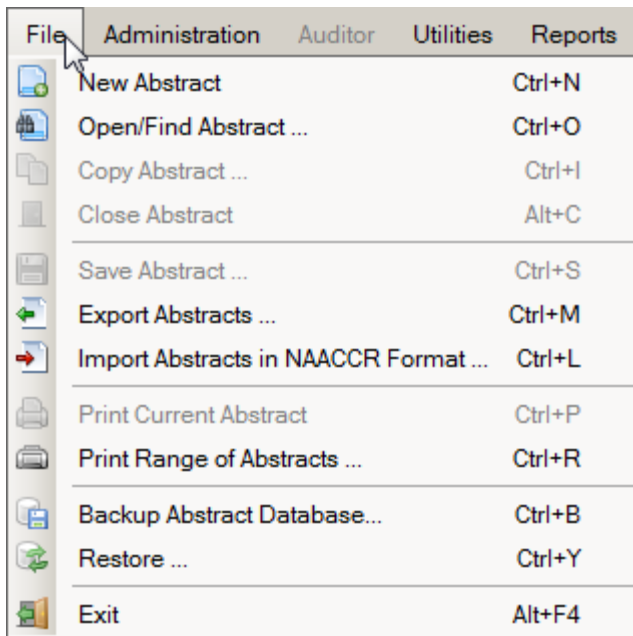


Tip

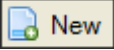
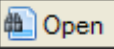
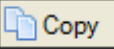
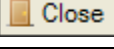
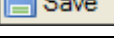
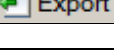
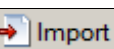
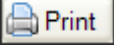


The File Menu

The File menu is used to access the majority of features that are used to work with abstracts. To access the File menu items, click on the **File** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



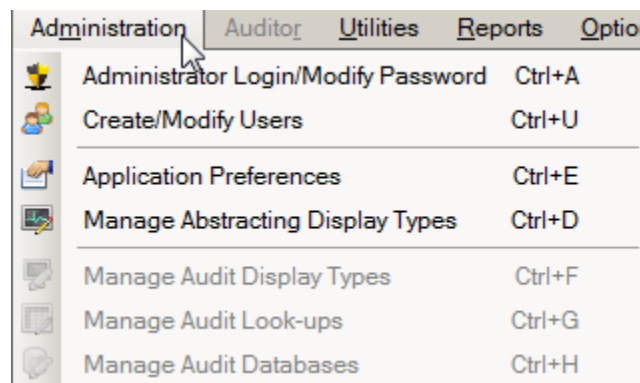
The following table describes the Abstract Plus File menu sub-options:

Sub-option (Keystroke)	Toolbar Icon	Function
New Abstract (Ctrl+N)		Create a new abstract
Open/Find Abstract... (Ctrl+O)		Search for and open an existing abstract
Copy Abstract... (Ctrl+I)		Copy an open abstract
Close Abstract (Alt+C)		Close an open abstract
Save Abstract... (Ctrl+S)		Save entered information
Export Abstracts... (Ctrl+M)		Export abstracts out of the Abstract Plus database into a NAACCR-formatted file
Import Abstracts in NAACCR Format... (Ctrl+L)		Import abstracts in a NAACCR-formatted file into the Abstract Plus database
Print Current Abstract (Ctrl+P)		Preview the displayed abstract and/or print it
Print Range of Abstracts... (Ctrl+R)		Select and print a range of abstracts or save in a file
Backup Abstract Database (Ctrl+B)		Create backup database to be used by Restore feature if database becomes corrupted

Sub-option (Keystroke)	Toolbar Icon	Function
Restore... (Ctrl+Y)		Restore/replace corrupted database with a previously saved backup database
Exit (Alt+F4)		Log off Abstract Plus with an option to back up the database with your work

The Administration Menu

The Administration menu is used to access the administrative features of the program, such as managing user accounts and setting up the application for abstraction and auditing. No toolbar icons are available for any Administration menu options. To access the Administration menu items, click on the **Administration** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



Entry of a special Administrator password is required in order to access the Administration menu items; the application will prompt you for the Administrator password when you attempt to access any of the Administration menu items.

The following table describes the Abstract Plus Administration menu sub-options:

Sub-option (Keystroke)	Function
Administrator Login/Modify Password (Ctrl+A)	Log in as Administrator or change the Administrator password
Create/Modify Users (Ctrl+U)	Add, edit, or delete a user account or reset a password
Application Preferences (Ctrl+E)	Maintain all general, security, database and report application settings
Manage Abstracting Display Types (Ctrl+D)	Create, edit, or delete display types available for the abstracting features

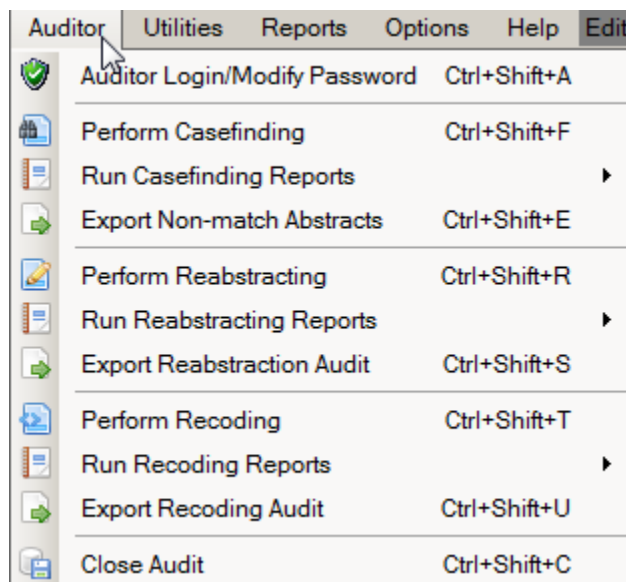
Sub-option (Keystroke)	Function
Manage Audit Display Types (Ctrl+F)	Create, edit, or delete display types available for the auditing features (currently disabled)
Manage Audit Look-ups (Ctrl+G)	Maintain special audit lookup tables (currently disabled)
Manage Audit Databases (Ctrl+H)	Create, edit, or delete audit databases (currently disabled)

**Note**

The Manage Audit Display Types, Manage Audit Look-ups and Manage Audit Databases functions are currently disabled.

The Auditor Menu

The Auditor menu is used to access all of the available auditing features, such as opening and closing audits, and performing casefinding, reabstraction, and recoding audits. No toolbar icons are available for any Auditor menu options.

**Note**

The Auditor features are currently disabled. Description of Auditor features provided in this manual is for informational purposes only.

The following table describes the Abstract Plus Auditor menu sub-options:

Sub-option (Keystroke)	Function
Auditor Login/Modify Password (Ctrl+Shift+A)	Login as Auditor, and/or modify Auditor password
Perform Casefinding (Ctrl+Shift+F)	Perform a casefinding audit on opened audit
Run Casefinding Reports	Run casefinding audit pre-reconciliation and final reports
Export Non-match Abstracts (Ctrl+Shift+E)	Export unreported tumors found upon casefinding audit in NAACCR file format
Perform Reabstracting (Ctrl+Shift+R)	Perform a reabstracting audit on opened audit
Run Reabstracting Reports	Run reabstraction audit pre-reconciliation and final reports
Export Reabstraction Audit (Ctrl+Shift+S)	Export text file with reabstracting audit data for further analysis
Perform Recoding (Ctrl+Shift+T)	Perform a recoding audit on opened audit
Run Recoding Reports	Run recoding audit pre-reconciliation and final reports
Export Recoding Audit (Ctrl+Shift+U)	Export text file with recoding audit data for further analysis
Close Audit (Ctrl+Shift+C)	Close the audit

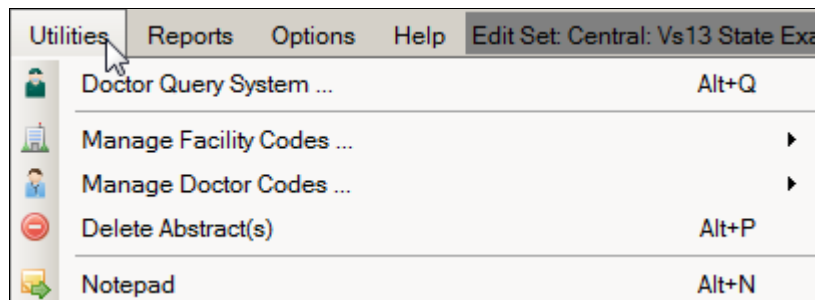
**Note**

The Manage Audit Display Types, Manage Audit Look-ups and Manage Audit Databases functions are currently disabled.

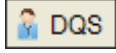
Utilities Menu

The Utilities menu is used to access a few supplementary functions included in the program, such as re-running edits in batch mode, querying your local database of doctors, managing facility and doctor codes, and deleting abstracts.

To access the Utilities menu items, click on the **Utilities** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



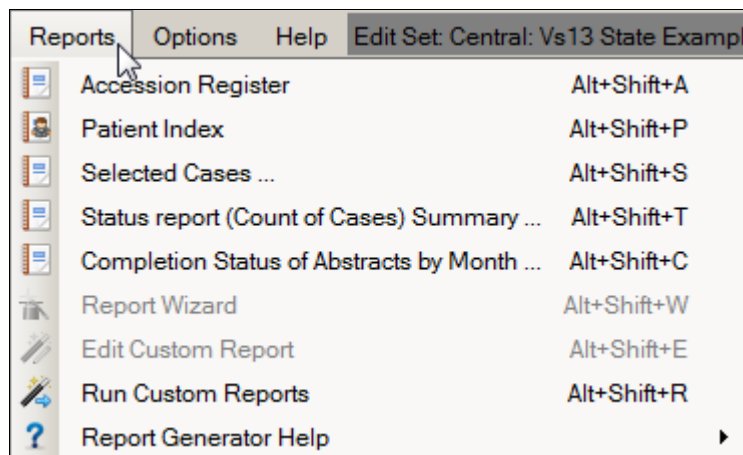
The following table describes the Abstract Plus Utilities menu sub-options:

Sub-option (Keystroke)	Toolbar Icon	Function
Doctor Query System (Alt+Q)		Query and search the doctor database; DQS can be accessed whether or not an abstract is opened, or a physician field selected
Manage Facility Codes...		Import (can use Alt+I keystroke) or edit (can use Alt+J keystroke) local facility codes
Manage Doctor Codes...		Import (can use Alt+K keystroke) or edit (can use Alt+L keystroke) local physician codes
Delete Abstract(s) (Alt+P)		Delete selected abstracts
Notepad (Alt+N)		Launch Notepad to view created text files

The Reports Menu

The Reports menu is used to access all of the available reports regarding abstracts in the Abstract Plus database. No toolbar icons are available for any Reports menu options.

To access the Reports menu items, click on the **Reports** menu item, and select the desired report, or use the appropriate keystroke combination for the desired report.



The following table describes the Abstract Plus Reports menu sub-options:

Sub-option (Keystroke)	Function
Accession Register (Alt+Shift+A)	Opens the Accession Register Report, which includes a line listing of all abstracts in the database, sorted by reporting hospital and accession number

Sub-option (Keystroke)	Function
Patient Index (Alt+Shift+P)	Opens the Patient Index Report, which includes a line listing of all abstracts in the database, sorted alphabetically by name
Selected Cases (Alt+Shift+S)	Opens a line listing report which includes abstracts based on user-specified criteria
Status Report (Count of Cases) Summary... (Alt+Shift+T)	Opens a report that includes the total number of complete and incomplete abstracts by export status within a user-specified date range
Completion Status of Abstracts by month (Alt+Shift+C)	Opens a report that includes abstract completion status by year and month of Date of Adm/1 st Contact within a user-specified date range
Report Wizard (Alt+Shift+W)	Newly-added feature to enable users to generate their own custom reports (currently disabled)
Edit Custom Reports (Alt+Shift+E)	Edit an existing custom report (currently disabled)
Run Custom Reports (Alt+Shift+R)	Runs selected custom reports that have been added to the application using the Report Wizard
Report Generator Help	Opens online help for the Report Wizard; optional installation by Administrator required (currently disabled)

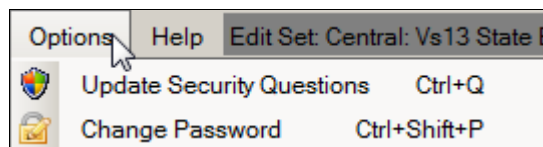
**Note**

The Report Wizard, Edit Custom Reports and Report Generator Help functions are currently disabled.

The Options Menu

For security purposes, users may want to change their passwords and security questions on a routine basis. The Options menu is used to update the user's security questions or change their password. No toolbar icons are available for any Options menu selections.

To access the Options menu items, click on the **Options** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



The following table describes the Abstract Plus Options menu sub-options:

Sub-option (Keystroke)	Function
Update Security Questions (Ctrl+Q)	Opens the Update User's Security Questions window with the current User ID displayed along with the current security questions and answers specified by the user; new answers to existing questions may be entered, as well as new questions and answers
Change Password (Ctrl+Shift+P)	Opens Change User's Password window, where the user can enter their current password, and a new password in both New Password and Confirm Password in order to change their password

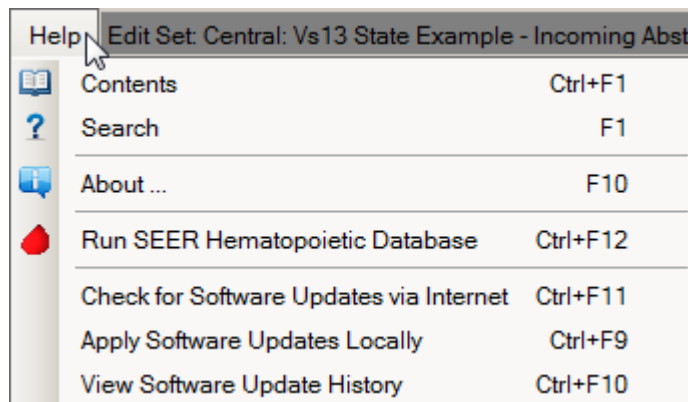


Note

For more information regarding updating personal security questions, see page 31 of this manual or click [here](#). For more information regarding changing your general user password, see page 27 of this manual or click [here](#).


The Help Menu

The Help menu is used to access the online help that is available within the program. To access the Help menu items, click on the **Help** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



The following table describes the Abstract Plus Help menu sub-options:

Sub-option (Keystroke)	Toolbar Icon	Function
Contents... (Ctrl+F1)		View the contents of Abstract Plus online Help
Search for help on... (F1)		Enter search terms for topics on which you need more information

Sub-option (Keystroke)	Toolbar Icon	Function
About (F10)		View Abstract Plus, Collaborative Staging, and Edits metafile version information
Run SEER Hematopoietic Database		Launch the SEER Hematopoietic Database stand-alone application to help you code hematopoietic and lymphoid neoplasms cases diagnosed beginning January 1, 2010
Check for Software Updates via Internet (Ctrl+F11)		Check for Software Updates via the Internet (Internet connection required)
Apply Software Updates Locally (Ctrl+F9)		Apply software updates that have been distributed (no Internet connection required)
View Software Update History (Ctrl+F10)		View historical software updates that have been applied via the Abstract Plus Auto-update Feature



Currently, the Check for Software Updates via Internet DO NOT apply to the Michigan customized versions of Abstract Plus. Michigan users of Abstract Plus should refer to the Michigan installation instructions for downloading and upgrading of Abstract Plus.

Abstract Plus Abstracting and Editing Features

One of the primary activities that Abstract Plus is used for is the abstraction of information from medical records. As mentioned, Abstract Plus has been entirely reprogrammed using .NET technology, and has a new, extremely user-friendly abstracting interface. New direct grid entry of coded values and quick select options for pull-down menus allow for an easy, streamlined abstracting experience, as well as easier viewing of text fields, online help, and edit errors.

The Abstract Plus Abstracting Process

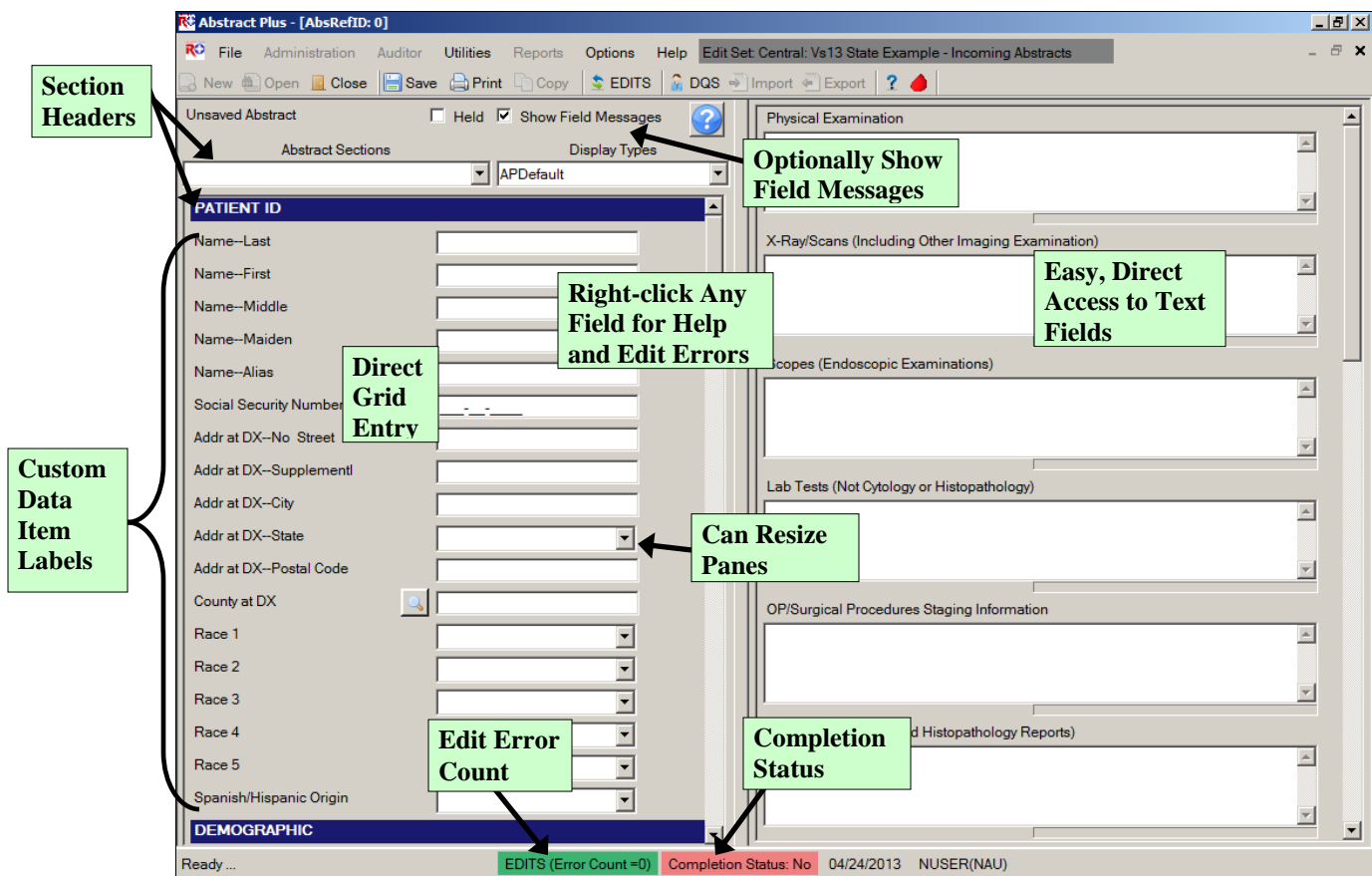
The basic process of generating and updating an abstract is as follows:

- i. Create the abstract with the patient's identifiers, such as name and social security number and save. After you create an abstract, you can save it at any time and return to your work at a later time.
- ii. Enter codes and text in the data entry fields. Save the abstract to retain the information you have entered.
- iii. Correct errors. Each time you open or save the abstract, Abstract Plus can automatically edit the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.

- iv. After you have entered all your data and corrected all errors, the system saves your new abstract as complete. You will see the edits error count and completion status indicators at the bottom of the abstracting window turn from red to green, indicating that the abstract is complete.

The Abstract Plus Abstracting Window

The Abstract Plus Abstracting window is divided into 2 main sections: a data entry grid for coded values on the left, and a data entry grid for text fields on the right. When you left-click and hold your mouse on the vertical divider bar in the center of the window, a splitter is highlighted which you can drag to the left or right to resize the view of codes or text fields, and the application remembers your last placement of the divider bar. You can vertically scroll the view of coded values and text fields independently to easily and concurrently view codes and associated text.



The Abstract Plus user-friendly abstracting interface includes all new abstracting features. Please see page 54 of this training manual, or click [here](#) for more information regarding Abstract Plus abstracting features.

The abstracting interface is called a **display type**. A display type basically includes information regarding the fields displayed/collected, critical (or required) fields, edit set selections, and collaborative staging preferences, and is configured by your Abstract Plus Administrator upon setup of the application. The data items in a display type are labeled and ordered by your Administrator, as well as grouped into logical sections, which also have customizable labels.

**Note**

Regardless of the customized label a data item may have, when a data item is selected, the associated NAACCR item name is always displayed in the lower left-hand corner of the window. This information is helpful when looking up information regarding a data item in the online help reference books.

Data Quality Edits and Error Resolution Features

The screenshot displays the Abstract Plus application window. On the left, the 'PATIENT ID' section contains fields for Name-Last (DOE), Name-First (JOHN), Name-Middle (M), Name-Maiden, Name-Alias, Social Security Number (999-99-9999), Address (123 EAST MAIN ST, ATLANTA, GA - Georgia, 999999999, 087), and Race (01 - White). Below this is the 'DEMOGRAPHIC' section. On the right, the 'Edit Set Results' window is open, titled 'All Edit Errors'. It lists several errors for the 'Central: Vs13 State Example - Incoming Abstracts' edit set, including 'Cause of Death (SEER COD)', 'Class of Case (COC)', 'ICD Revision Number (NPCR)', and 'Reporting Facility (NPCR)'. Each error message includes a description, a link to 'Edit Description', and the specific field value that caused the error (e.g., '<BLANK>'). The status bar at the bottom indicates 'EDITS (Error Count = 17)'.

Each time an abstract is opened or saved; Abstract Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.

**Important**

You **MUST** resolve all edit errors and fill in all critical (required) fields in order to **complete** the abstract.

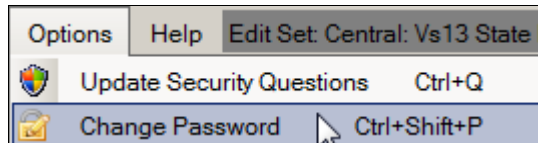
Abstract Plus has edit error display features that greatly facilitate the error resolution process. Editing features include display of the **name of the edit set** being run at the top of the abstracting window and an all-new **Edit Set Results** window. Please see page 166 of this training manual, or click [here](#) for more information regarding Abstract Plus editing features.

Changing Your General User Password

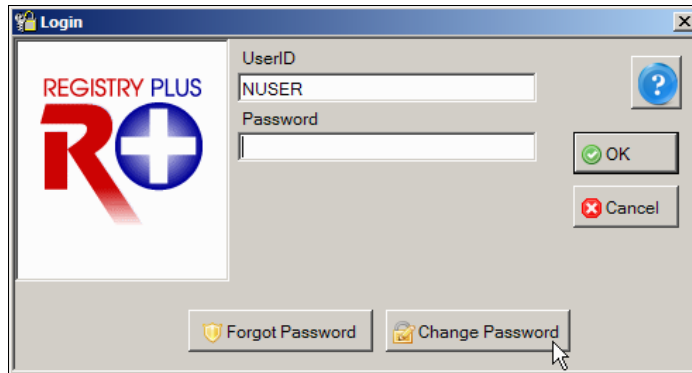
For security purposes, you may be prompted to change your general user password periodically, based on the Password Policy specified by your Abstract Plus Administrator. Your Administrator specifies your password requirements, how often you need to change your password, as well as how many of your last passwords you cannot repeat.

To change your Abstractor/general user password, complete these steps:

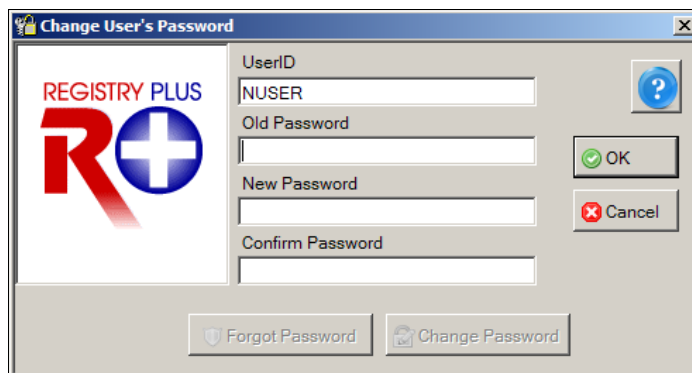
1. Open the **Change User's Password** window. This may be done in 2 ways:
 - a. From **Options Menu**, select **Change Password**.



- b. When logging in to Abstract Plus, enter your **User ID**, tab or click into the Password box, and then click **Change Password** on the Login window.



Result: The **Change User's Password** window opens, with your User ID displayed.



2. Enter your **Current Password** in **Old Password** box.

3. Enter a **New Password** in **New Password** box that meets the password requirements specified by your Abstract Plus Administrator.

**Note**

If your Administrator has made no changes, by default, your new password must be between 8 and 20 characters, contain at least one digit and one alphabetical character, and must not contain any special characters.

4. Re-enter your **New Password** in the **Confirm Password** box.

5. Click **OK** to change your password.

Result: Your password is changed, and the Abstract Plus main window is opened.

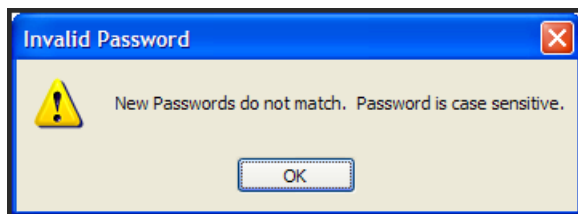
Possible Errors when Changing Your Password

There are three possible errors you may receive when attempting to change your password:

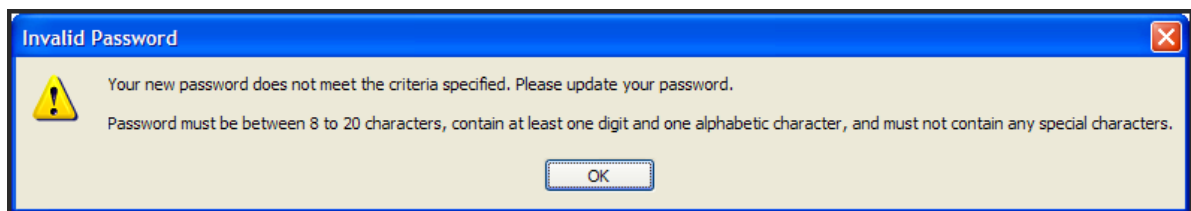
1. **Old password is incorrect.** You must correctly enter your old password in order to successfully change it. Click **OK**, and then correctly re-enter your old password.



2. **New passwords do not match.** The new password entered into the **New Password** and **Confirm Password** boxes must match exactly. Click **OK**, and then correctly re-enter your new password in the New and Confirm password boxes.



3. **New password does not meet specified password requirements.** Your new password must meet the password requirements specified by your Abstract Plus Administrator. Click **OK**, and then re-enter a new password that meets the stated password requirements.



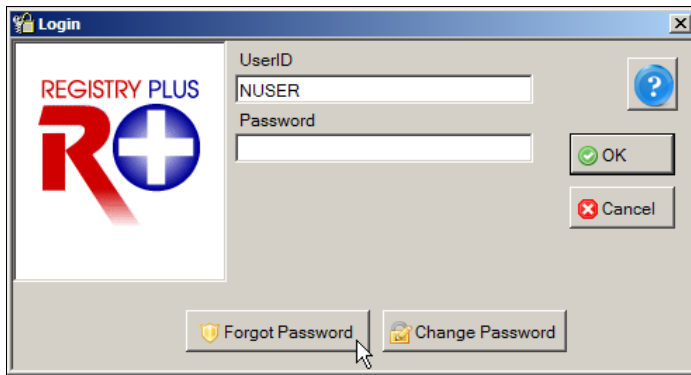
Resetting a Forgotten Password

In the event that you should forget your password, Abstract Plus has a security challenge question feature that will allow you to reset your own password without having to contact your Administrator. The security challenge question feature enables you to securely reset your password by answering a specified number of the security questions that you selected and answered upon initial login to Abstract Plus.

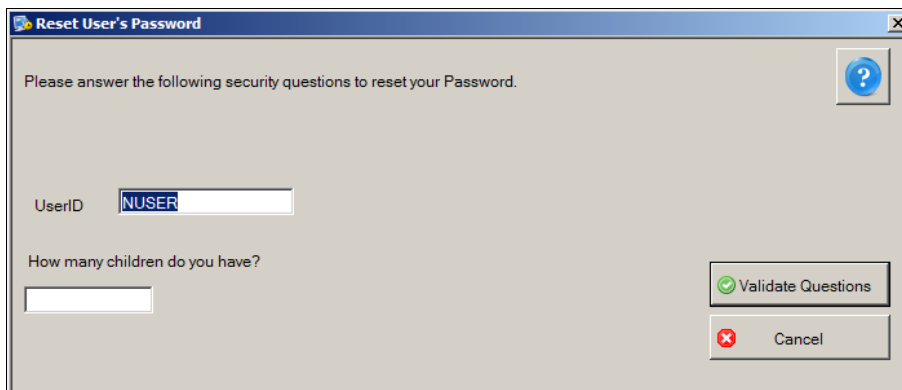
Your answers to these questions are used to validate your identity; Abstract Plus will ask you for the answers you provided to your chosen security questions, and then allow you to reset your password if the questions are answered correctly. If you forget both your password and your answers to your security questions, you will need to have your Abstract Plus Administrator reset your password.

To reset your password if you have forgotten it, complete these steps:

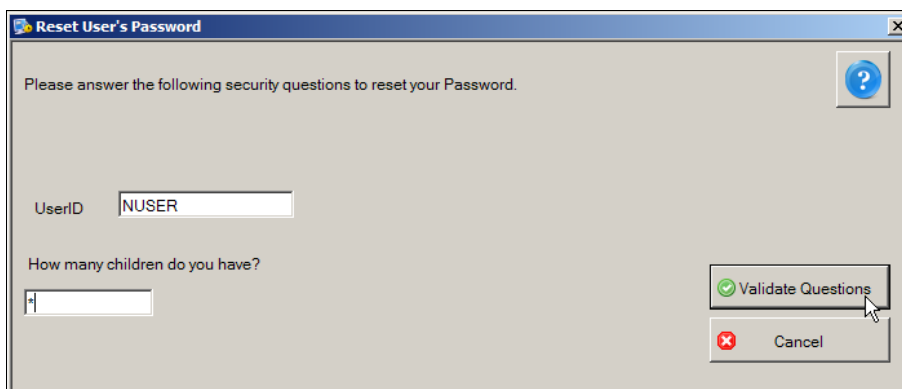
1. When logging in to Abstract Plus, enter your **User ID**, tab or click into the Password box, and then click **Forgot Password** on the Login window.



Result: The **Reset User's Password** window opens, with your User ID displayed, as well as the number of security questions specified by your Administrator upon set up of Abstract Plus.



2. Enter the answer to each displayed question with the same answer you provided upon initial login to Abstract Plus.



3. Click **Validate Questions** once all questions are answered.

Result: The **Reset User's Password** window opens, with your User ID displayed.

4. Enter a **New Password** in both the **New** and **Confirm** password boxes, and then click **Reset Password**.

Result: The **Forgot Password** window opens, with your User ID displayed.

5. Enter your **New Password** in Password box, and click **OK**.

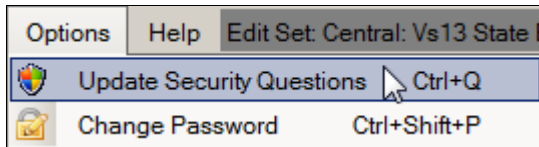
Result: The Abstract Plus **main window** opens, with you logged in as a general user. Your password has been successfully set to the new password you have specified.

Updating Personal Security Questions

Once you are logged in to Abstract Plus, you can update your selected security questions and/or answers at any point. For example, if you selected the security question of “How many children do you have?” and you just had a new child enter your family, you can update your answer to this question.

To update your security questions and/or answers, complete these steps:

1. From **Options Menu**, select **Update Security Questions**.



Result: The **Update User's Security Questions** window opens, with your User ID displayed, as well as the current security questions and answers which you have specified. For added security asterisks are displayed rather than your answers to the questions.

A screenshot of the 'Update User's Security Questions' window. The window has a title bar with the text 'Update User's Security Questions'. Below the title bar, there is a message: 'Your current security question and answer selections are listed below. Revise your selections as necessary and click Submit Questions.' Below this message, there is a 'UserID' field with the value 'NUSER'. There are three security questions listed, each with a dropdown menu for the question and a text field for the answer. The questions are: 'How many siblings do you have?', 'How old were you at your wedding? (Enter age as digits.)', and 'How many children do you have?'. The answers are masked with asterisks. To the right of the questions, there are two buttons: 'Submit Questions' (with a green plus icon) and 'Cancel' (with a red X icon).

2. You can select new questions and answer them or supply new answers to your previously selected questions. When you have completed your changes, click **Submit Questions**.

A screenshot of the 'Update User's Security Questions' window, similar to the previous one. In this screenshot, the 'Submit Questions' button is being clicked by a mouse cursor. The 'How many children do you have?' question now has the answer '2' entered in the text field instead of asterisks. The 'Submit Questions' button has a green plus icon, and the 'Cancel' button has a red X icon.

Result: You are returned to the Abstract Plus **main window** with your changes saved for future use.

Abstract Plus Auto-update Feature

Abstract Plus version 3.3.1.2 includes a new “Auto-update” feature, which enables delivery of application bug fixes, enhancements and updates associated with Abstract Plus via the

Internet after software distribution and initial installation. This new mechanism downloads the necessary applicable files from the CDC Abstract Plus FTP site and replaces the existing files with the updated/revised versions to apply updates/fixes. In the event that you are an Abstract Plus user that does not have access to the Internet, software update packages can be distributed to you and you can apply them locally from a folder on your computer or network.

Two modules are included in the in the Auto-update feature, so that revisions, fixes, or updates can be made from the CDC and or state levels:

1. **Generic Auto-update Module:** This module primarily delivers application enhancements, updates, and resolutions to identified problems that are applicable regardless of the state, region, or project for which Abstract Plus has been customized. It will also be used to update the generic version of Abstract Plus available from the NPCR website. The generic auto-update module will deploy updates for issues identified at the CDC-level, including, but not limited to: resolutions to identified issues, updated example display types, edits metafiles, online help files, revisions to the Catvals tables, and updated application files.

For example, the initial release of Abstract Plus 3.3 will include a version of RPOH that will include the NAACCR Version 13.0 Volume II Data Dictionary and the updated Abstract Plus User's Guide. As soon as additional manuals are added to RPOH, they will be distributed via the generic auto-update module.

2. **Custom Auto-update Module:** This module also works in the same manner as "Generic Auto-update", but addresses updates to customizations made for a certain state or project. This module identifies the Abstract Plus user's customized version, and downloads the update package version for their specific installation.

Benefits of the Auto-update Feature

Many states have a large number of Abstract Plus end users and even more individuals download and use the generic version of Abstract Plus. With each new version that is released, sometimes issues are identified that need to be corrected, or a state decides to make a change to their customizations. As a result, if issues/revisions are identified after a state has distributed the program, the state may have to obtain a new installation and re-distribute. For some states this is a very onerous process, and often the end user would need to uninstall and re-install the application which is quite inconvenient. States often have to assess the value added of a specific correction or update, i.e., is it worth going through redistribution of the software?

In order to alleviate states and end users from the time and resource-consuming efforts of redistribution, the CDC has programmed a new Auto-update feature.

No Uninstall and Re-install of Abstract Plus is Necessary

After the initial installation of the application, the new Auto-update mechanism does not require the end user to uninstall/reinstall the application to obtain software updates. It simply replaces the associated files on the CDC FTP site with those already installed on the end users computer.

No Loss of Data is Possible

Although it is highly recommended for the end user to back-up their data prior to launching the Auto-update, the Auto-update mechanism does not directly interfere or touch the user or abstract data. There is absolutely no possibility of any data loss when the user uses the Auto-update feature.

Auto-updates can be Implemented Automatically or Manually

There are two ways initiate the Auto-update mechanism via the Internet. There is a new Application Property that allows your Administrator to customize Abstract Plus to run the Auto-update feature automatically. The frequency with which the application automatically checks for updates can also be specified; there is a new option that allows the state to specify how the number of days in-between checking for available updates. In addition, the abstractor can check for software updates manually at any time.

Automatic Detection of Available Updates for Customized Versions

Once the Auto-update feature is invoked, Abstract Plus looks to an XML file (AvailableUpdateInfo.xml) on the CDC FTP Server. This XML includes all the update information that is systemically organized. Every time CDC releases an update (states will communicate customization updates to the CDC and CDC will update the XML files and post the appropriate files to the CDC FTP site), CDC updates this file with appropriate information (See sample XML file below).

```
<?xml version='1.0'?>
<RegistryPlusApplications>
<Application Name = 'ABSTRACTPLUS'>
  <GenericPackage>
    <Version>1</Version>
    <DownloadPath>http://ftp.cdc.gov/pub/NPCR-AP-
UPDATES/AbstractPlus/GenericUpdate/GenericPackage_EDIT5-Fix_02-25-2013.zip</DownloadPath>
    <PrerequisitePackageVersion>0</PrerequisitePackageVersion>
    <PackageDescription>This update package will address issue associated with EDITS
for generic Abstract Plus. This issue was reported by Kathleen Thoburn on 02-25-2013.
    </PackageDescription>
    <RequiredNAACCRVersion>122</RequiredNAACCRVersion>
    <ReleaseMode>UAT</ReleaseMode>
  </GenericPackage>

  <PackageGroup Name ='GA'>
    <CustomPackage>
      <Version>1</Version>
      <DownloadPath>http://ftp.cdc.gov/pub/NPCR-AP-
UPDATES/AbstractPlus/CustomUpdate/GA/CustomPackage1.zip</DownloadPath>
      <PrerequisitePackageVersion>0</PrerequisitePackageVersion>
      <PackageDescription>
        This Custom update package version 1 for GA, has such and such updated
files..., etc.
      </PackageDescription>
      <ReleaseMode>UAT</ReleaseMode>
    </CustomPackage>

    <CustomPackage>
      <Version>2</Version>
      <DownloadPath>http://ftp.cdc.gov/pub/NPCR-AP-
UPDATES/AbstractPlus/CustomUpdate/GA/CustomPackage2.zip</DownloadPath>
      <PrerequisitePackageVersion>1</PrerequisitePackageVersion>
      <PackageDescription>
        This Custom update package version 2 for GA, has such and such updated
files..., etc.
      </PackageDescription>
      <ReleaseMode>UAT</ReleaseMode>
    </CustomPackage>
  </PackageGroup>
</Application>
</RegistryPlusApplications>
```

```
<CustomPackage>
  <Version>3</Version>
  <DownloadPath>http://ftp.cdc.gov/pub/NPCR-AP-
UPDATES/AbstractPlus/CustomUpdate/GA/CustomPackage3.zip</DownloadPath>
  <PrerequisitePackageVersion>2</PrerequisitePackageVersion>
  <PackageDescription>
    This Custom update package version 3 for GA, has such and such updated
files..., etc.
  </PackageDescription>
  <ReleaseMode>UAT</ReleaseMode>
</CustomPackage>
</PackageGroup>
```

Auto-updates can be Distributed and Implemented Locally (No Internet Connection Required)

In the event that you are an Abstract Plus user that does not have access to the Internet, software updates can be distributed to you and you can apply them locally from a folder on your computer or network.

Automatic Updates for Users Who Have Not Updated on a Regular Basis

If the automatic Auto-update system preference is not on, and a user does not check for updates for quite some time, several updates may have been released since they last checked for updates. The Auto-update mechanism keeps track of what updates were already applied and those that have not been applied, and will upgrade all released updates sequentially since the last update run to make the software current with all update releases.

User is Notified When the CDC FTP Site is Experiencing Issues

If the CDC FTP site is temporarily down, Abstract Plus displays a message to the user to try updating at a later time.

User is Notified When No Updates are Available

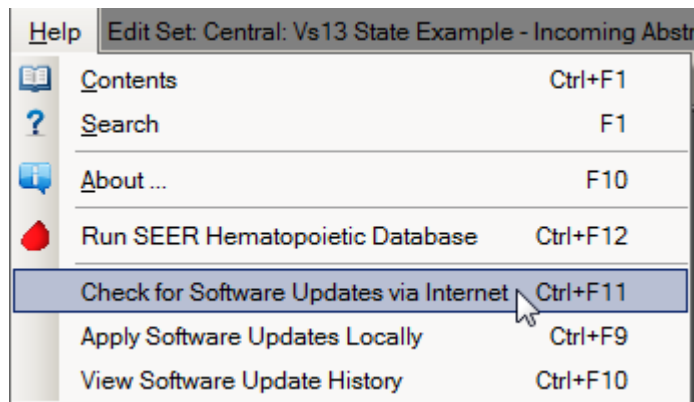
When the application or user checks for updates and there are no updates available Abstract Plus issues a message that states “No update is required at this time”.

Checking for Software Updates via the Internet

As mentioned earlier, Auto-updates can be implemented via the Internet automatically or manually via the Internet. Your software will automatically check for software updates via the Internet if your Administrator has set up Abstract Plus to do so. You can also manually check for auto-updates. Note that if your Administrator has configured the software to automatically check for updates, you can still manually check for updates at any time.

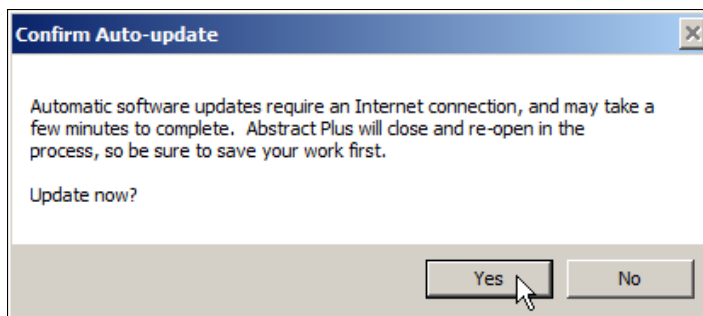
To check for auto-updates manually, complete these steps:

1. Open the Auto-update window. This can be done in 2 ways:
 - a. From **Help** Menu, select **Check for Software Updates via Internet**.



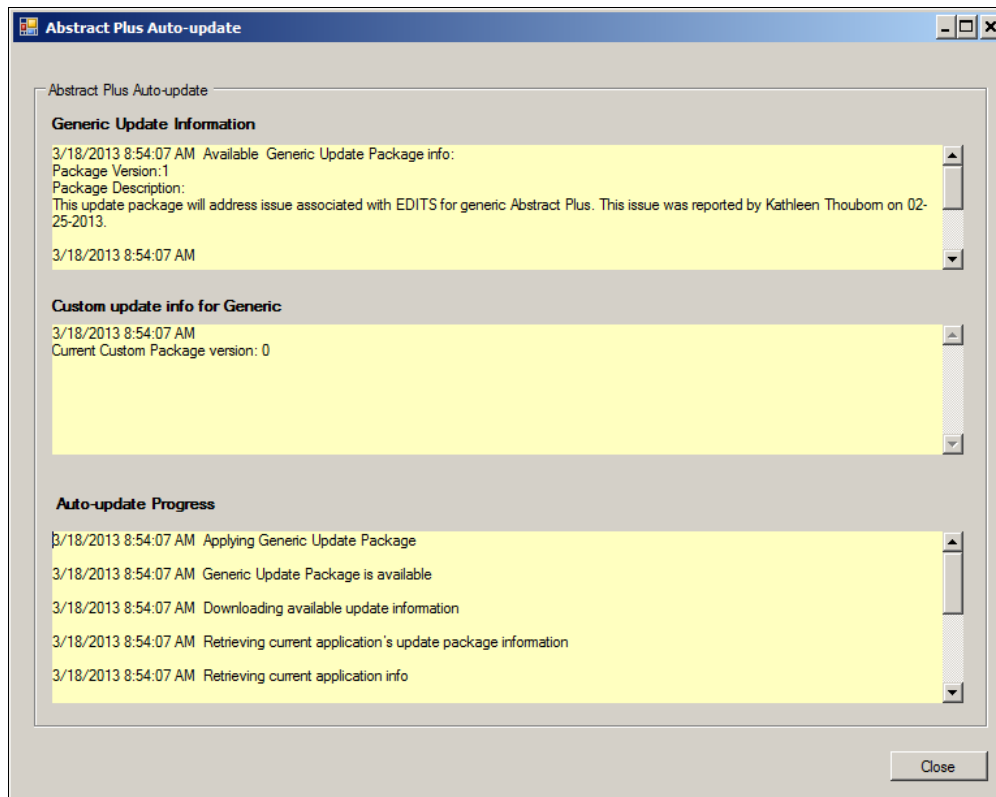
b. Use the keystroke **Ctrl+F11**.

Result: The **Confirm Auto-update** dialog box opens. As updating could be time-consuming task the application asks you to confirm that you would like to proceed with the update process.



2. Click **Yes**.

Result: The **Abstract Plus Auto-update** window opens, and the Auto-update mechanism begins. Abstract Plus will close and will then check for any available updates. If there are any applicable updates available Abstract Plus will download the update package(s) and begin updating Abstract Plus. Once the updates are applied, Abstract Plus will re-open. The Abstract Plus Auto-update window provides you with step-by-step feedback regarding the update process.



3. To close the Auto-update, click **Close**.

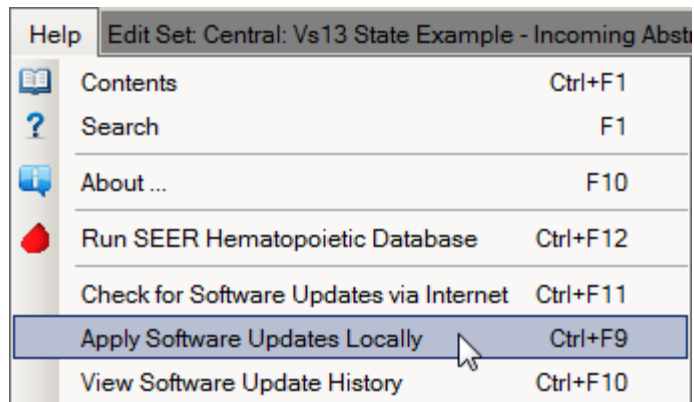
Result: The **Abstract Plus Auto-update** window will close, and Abstract Plus will re-open. You can now log back in and continue working in the application.

Applying Software Updates Locally

In the event that you are an Abstract Plus user that does not have access to the Internet, software update packages can be distributed to you and you can apply them locally from a folder on your computer or network. The Auto-update package comes in the form of a win-zipped file that just needs to be placed in a folder on your computer or network, and then you navigate to that folder.

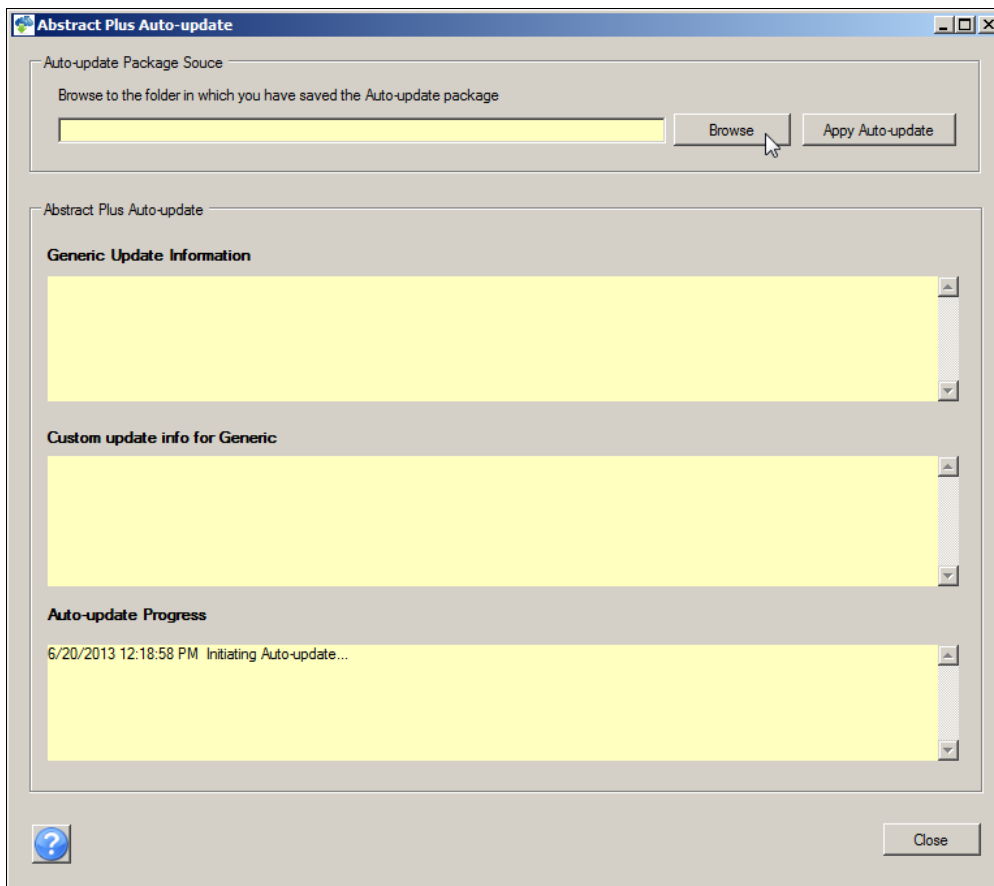
To apply software updates that have been distributed to you via an update package (e.g., via mailed CD), complete these steps:

1. Open the Auto-update window. This can be done in 2 ways:
 - a. From **Help** Menu, select **Apply Software Updates Locally**.



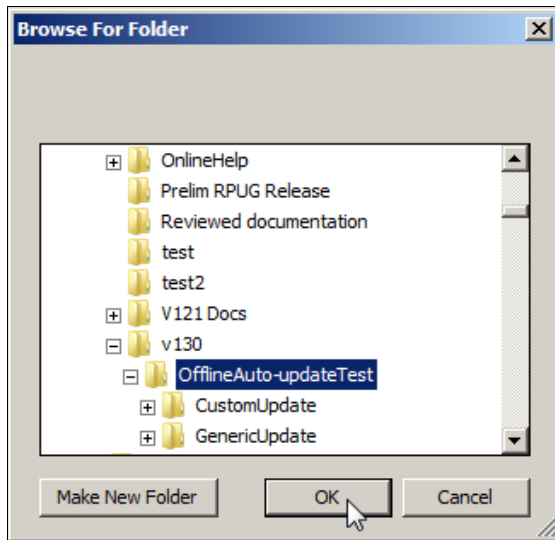
- b. Use the keystroke **Ctrl+F9**.

Result: The **Abstract Plus Auto-update window for local updates** opens.



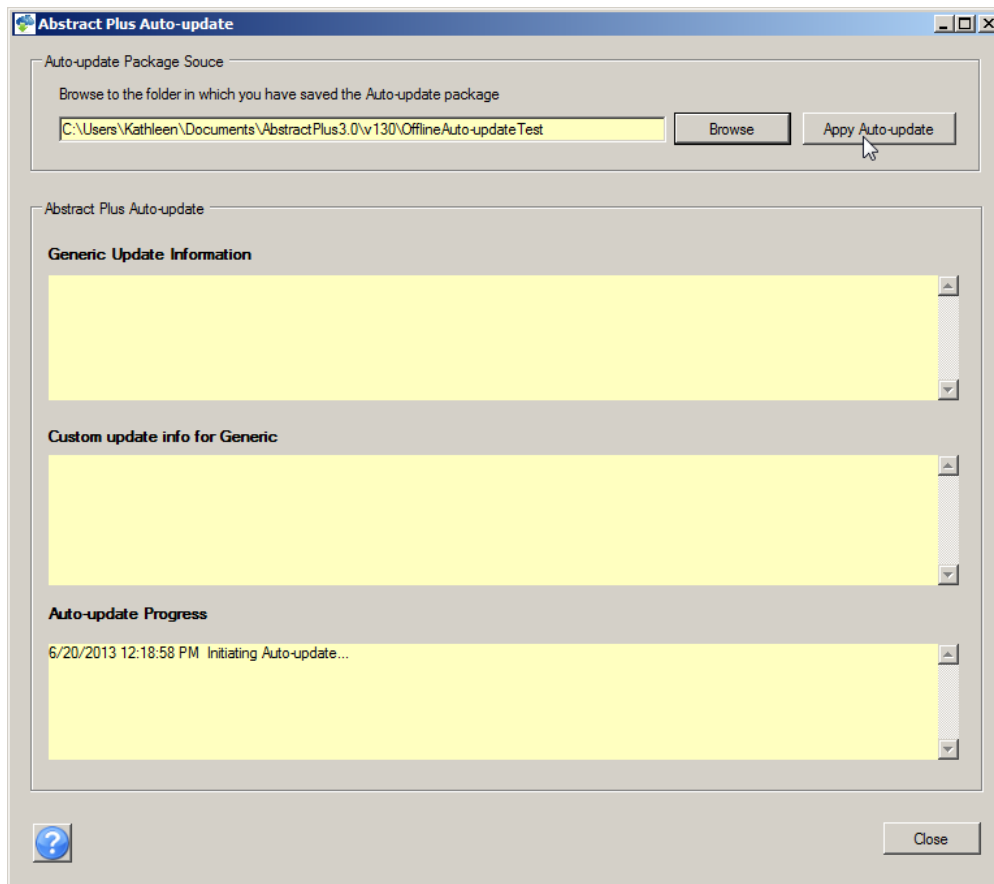
2. Click **Browse** to navigate to the folder on your computer or network in which you have saved the auto-update package that was distributed to you.

Result: The **Browse for Folder** window opens.



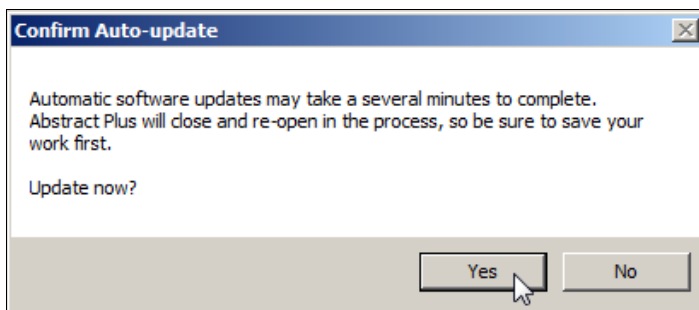
3. Navigate to the folder on your computer or network in which you have saved the auto-update package that was distributed to you and click **OK**.

Result: You are returned to the Abstract Plus Auto-update window for local updates, and the selected folder is displayed.



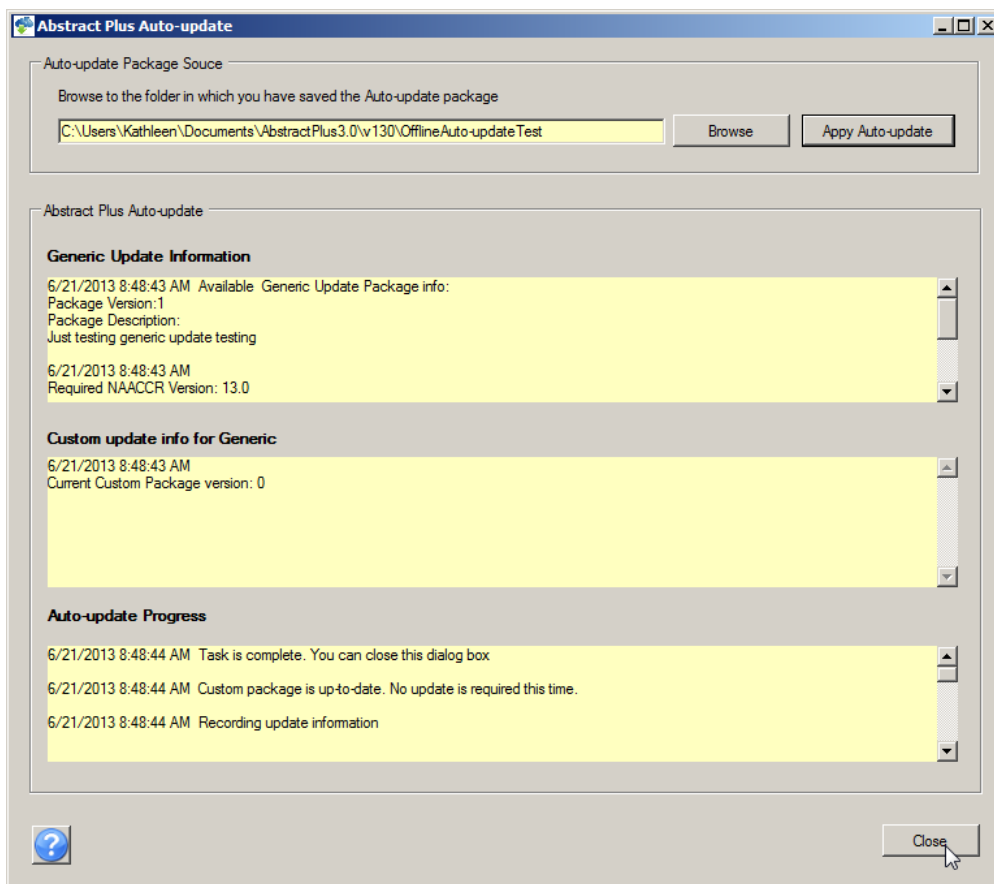
4. Click **Apply Auto-update**.

Result: The **Confirm Auto-update** dialog box opens. As updating could be time-consuming task the application asks you to confirm that you would like to proceed with the update process.



5. Click **Yes**.

Result: The **Abstract Plus Auto-update** window opens, and the Auto-update mechanism begins. Abstract Plus will close and will then check the specified folder for the available updates. The Auto-update process will begin and updates are applied. The Abstract Plus Auto-update window provides you with step-by-step feedback regarding the update process.



6. To close the Auto-update, click **Close**.

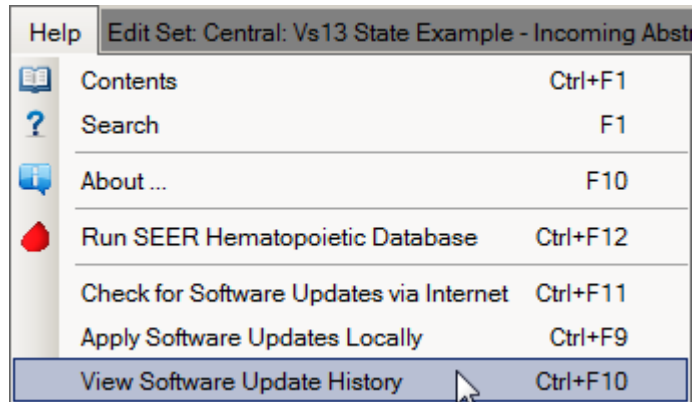
Result: The **Abstract Plus Auto-update** window will close, and Abstract Plus will re-open. You can now log back in and continue working in the application.

Viewing Software Update History

You can view your software update history to see if you have the latest software updates.

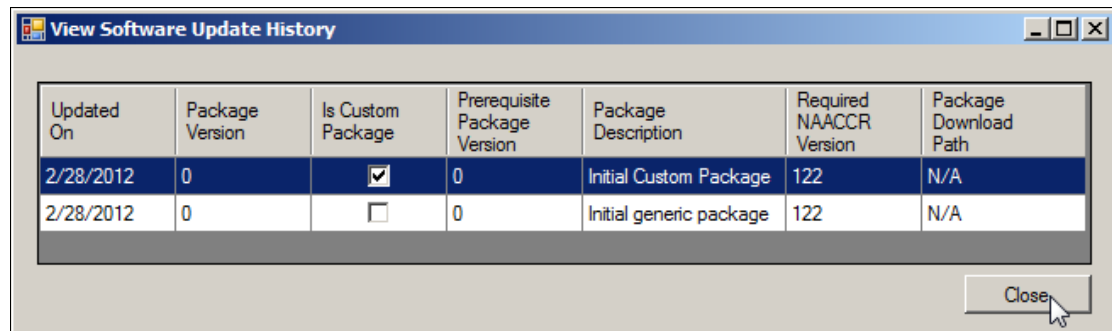
To view your software update history, complete these steps:

1. Open the **Software Auto-update History** window. This can be done in 2 ways:
 - a. Click on the **Help** menu, and select **View Software Update History**.



- b. Use the keystroke **Ctrl+F10**.

Result: The Abstract Plus **View Software Update History** window opens, and provides you with a listing of all updates you have implemented. A detailed description of each update is located in the Package Description column.



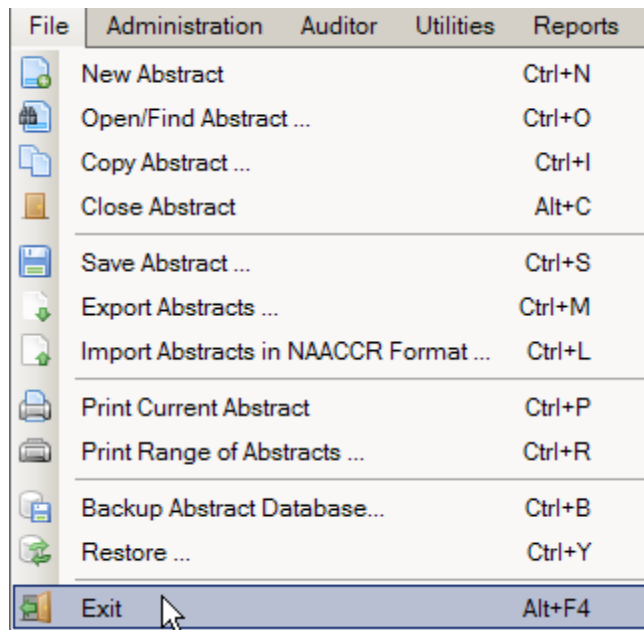
2. To close the **View Software Update History** window, click **Close**.

Exiting Abstract Plus and Using the Backup Option

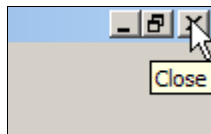
When logging off and exiting Abstract Plus, the application will prompt you to back up the current abstract database.

To log off / exit Abstract Plus and use the database backup option, complete these steps:

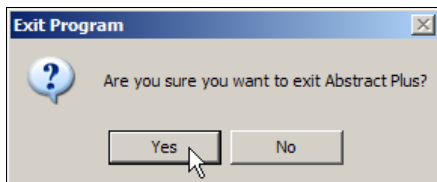
1. Exit Abstract Plus. This can be done in 3 ways:
 - a. Click on the **File** menu, and select **Exit**.



- b. Use the keystroke **Alt+F4**.
- c. Click the **X** in upper right corner of screen.

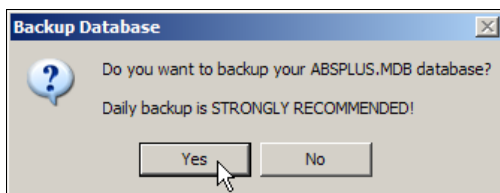


Result: The **Exit Program** window opens, and asks if you are sure you want to exit the program.



2. Click **Yes**.

Result: The **Backup Database** window opens, and asks if you would like to backup your Abstract Plus abstracts database (ABSPLUS.MDB).

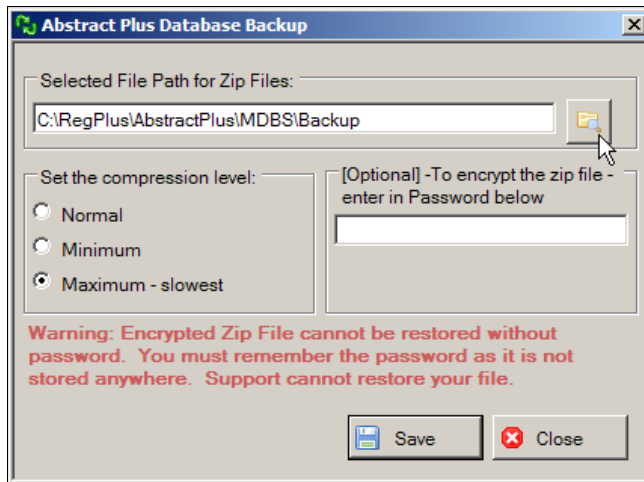



Important

Although you can choose not to backup your database, it is **highly recommended** that you backup your database after finishing an abstracting sessions during which changes were made (abstracts were added, updated, or deleted). Note that the Backup and Restore Database menu options **are not available when using SQL Server database**.

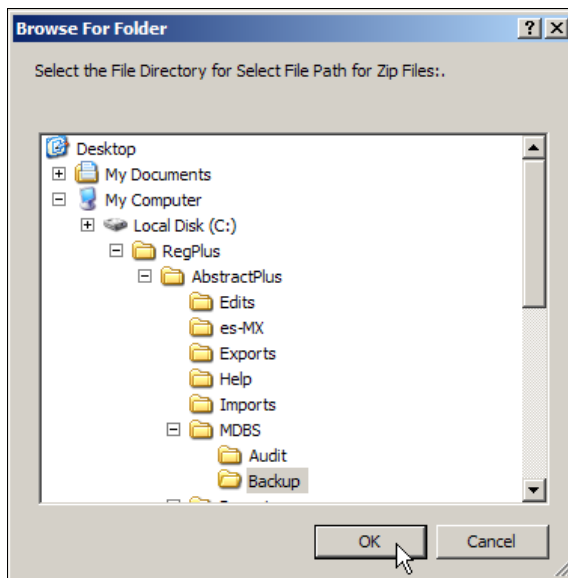
3. Click **Yes**.

Result: The **Abstract Plus Database Backup** window opens with defaults set.



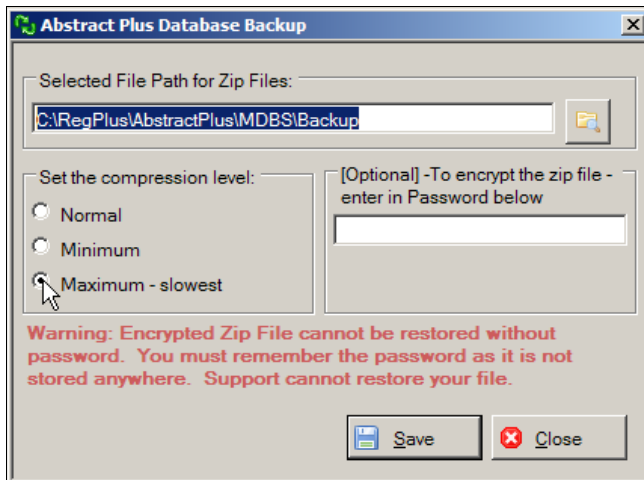
4. To change the default path, navigate to and identify the location on your computer or network where you would like to save your backup file by clicking the **Folder** icon .

Result: The **Browse for Folder** window opens.

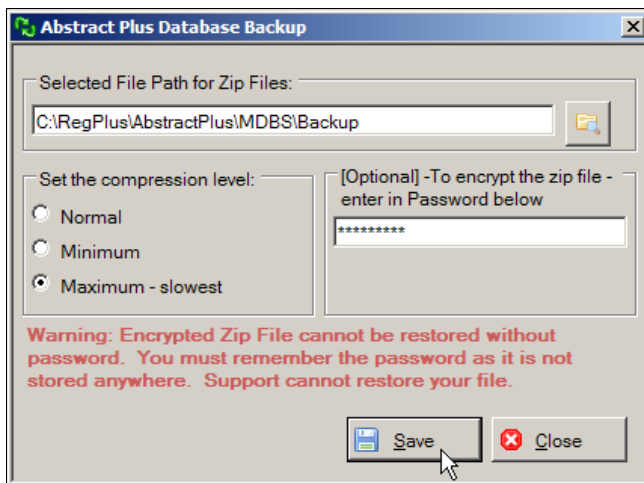


The default location for saving backup files is C:\RegPlus\AbstractPlus\MDBS\Backup. You may navigate to a different location if you so choose.

5. To accept the default location for saving the backup, click **OK**.
6. Select the desired **compression level** for the zip file if other than the default.

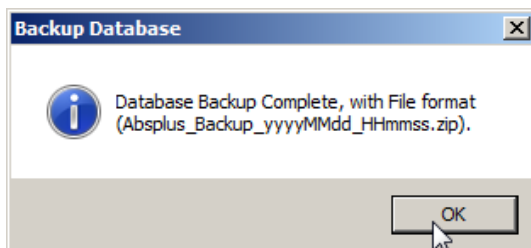


7. Enter a **password** (optional) to encrypt the zip file. Click **Save** to create the backup and exit or click **Close** to exit the application without saving the backup file.



If you choose to password-protect your backup file, the encrypted zip file **cannot** be restored without the specified password. It is very important that you remember this password!

Result: The backup is saved in the zip file, and a confirmation window opens. A progress bar is also displayed at the bottom of the screen.



A progress bar is also displayed at the bottom of the screen.

8. Click **OK**.

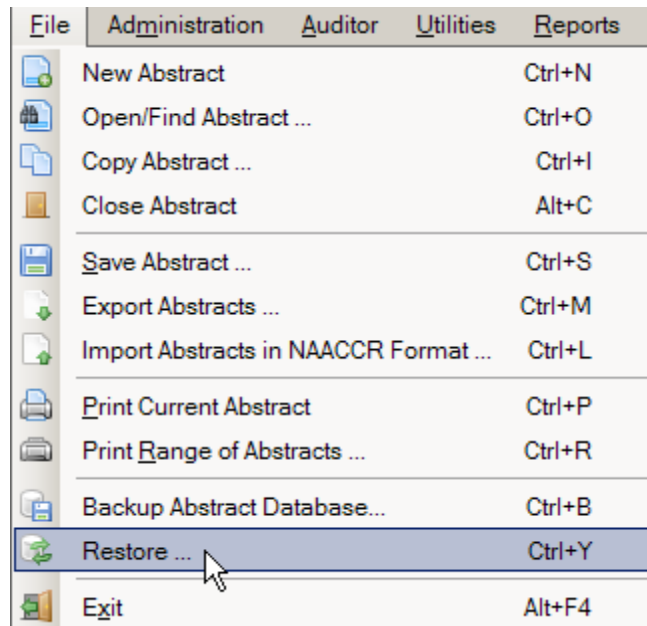
Result: The Abstract Plus application **closes**.

Using the Restore Option

In the event that your Abstract Plus abstracts database (ABSPLUS.MDB) is corrupted, if you have used the Backup option to backup your database you will be able to restore your database using the Restore option. The Restore option allows you to go back to a file that you saved with the same Abstract Plus version on a date when you encountered no problems. This is why it is so strongly recommended that you back up your work when exiting the application.

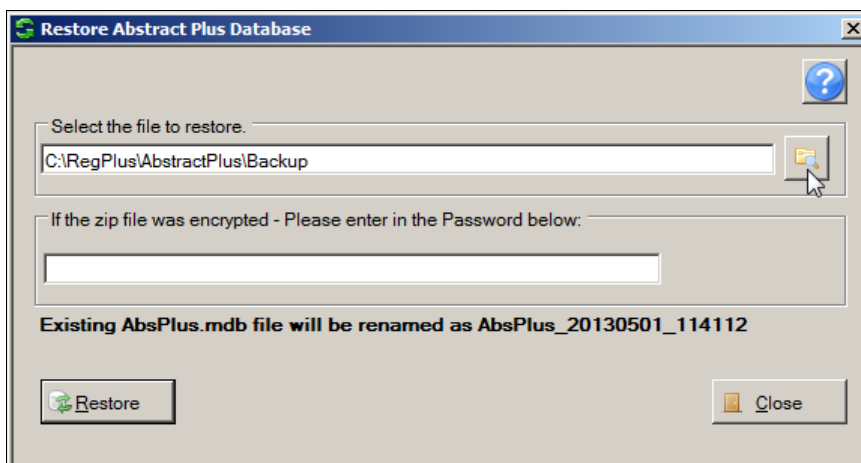
To use the Restore option to restore your Abstract Plus abstract database to an earlier saved backup, complete these steps:


1. Open the Restore Database window. This can be done in 2 ways:
 - a. Click on the **File** menu, and select **Restore**.



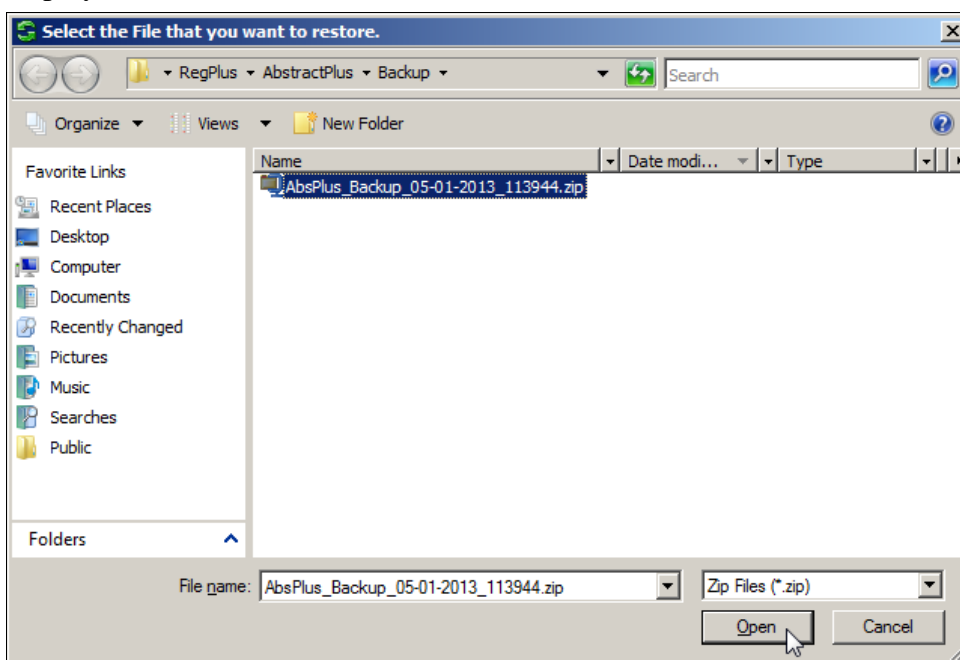
- b. Use the keystroke **Ctrl+Y**.

Result: The **Restore Abstract Plus Database** window opens.



2. Navigate to and identify the zipped backup file on your computer or network by clicking the **Folder** icon .

Result: The **Select the file you want to restore** window opens with a list of backup files displayed.



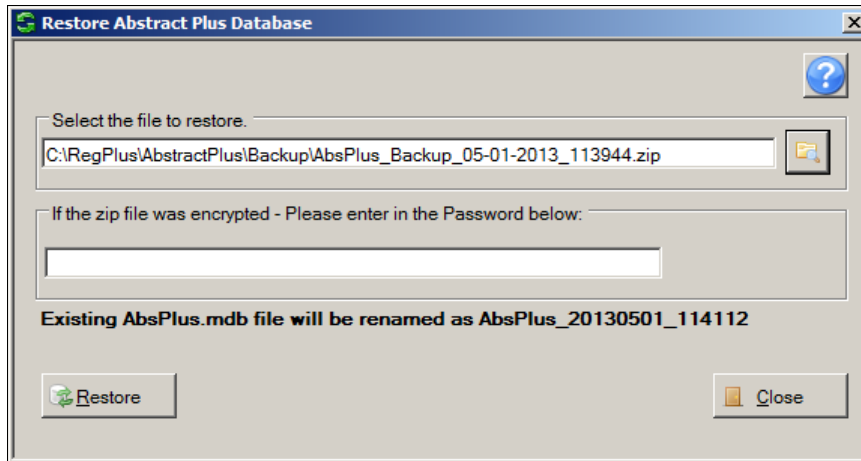
Note

The default location for saving backup files is

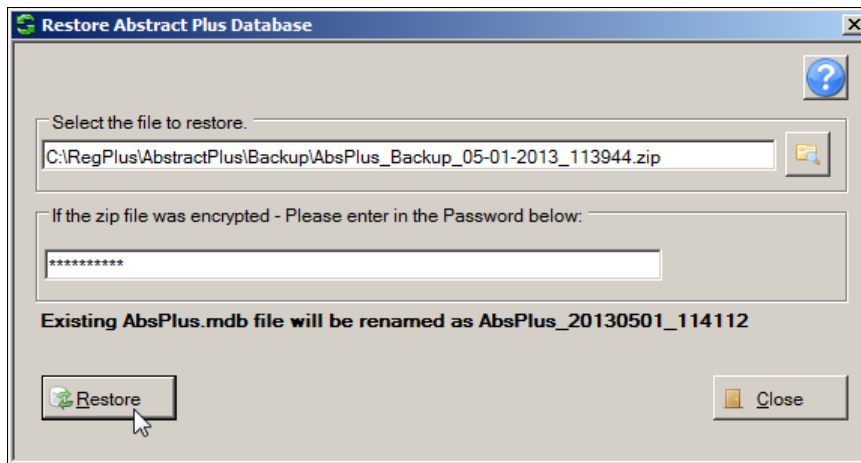
C:\RegPlus\AbstractPlus\MDBS\Backup. You may need to navigate to a different location if you saved your backup file in a location other than the default location.

3. Select the backup file to which you wish to restore your Abstract Plus abstract database, and click **Open**.

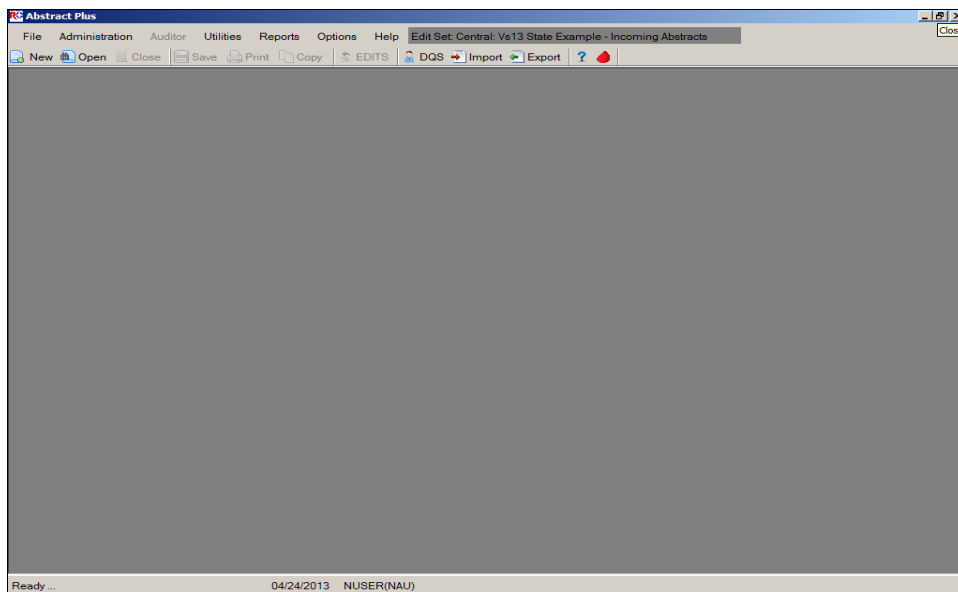
Result: You are returned to the **Restore Abstract Plus Database** window, with the selected backup file displayed.



4. If you password protected the selected backup file, enter the password in the password box, and click **Restore**.



Result: The Abstract Plus main window opens, with the selected abstracts backup database restored. You may now resume abstracting activities.



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Chapter 3: Working with Abstracts

Learning Objectives

In this chapter, you will learn to:

- Import abstracts into Abstract Plus
- Identify the areas in the Abstract Plus abstracting screen
- Create a new abstract
- Modify an abstract, including entering text, coding histologic type, and coding and deriving Collaborative Staging fields
- Correct errors in an abstract
- Copy an abstract
- Export abstracts
- Print a range of abstracts
- Use the Utility functions (Utilities)
- Use the Help functions to find out more information about fields

Overview

This chapter covers the basics about abstracting and working with abstracts in Abstract Plus. It includes a description of the process by which abstracts are generated, modified, edited, and completed, as well as how to print and copy existing abstracts and how to import and export abstracts in NAACCR file format.

You can start working with abstracts by

- Importing abstracts in NAACCR format
- Creating a new abstract
- Searching for and opening an existing abstract
- Copying an existing abstract and saving it as a new one

An existing abstract can be modified and the changes saved. Abstracts can also be exported in NAACCR format to any other system.

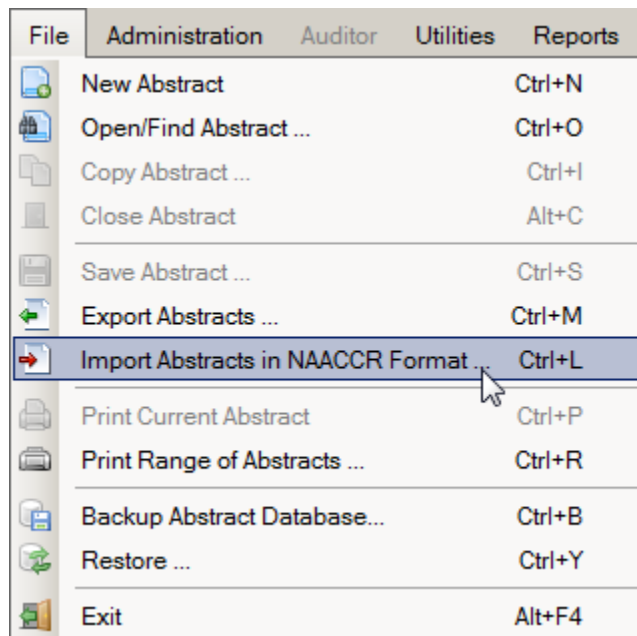
Importing Abstracts

You can import abstracts in NAACCR format from any system into Abstract Plus. Both complete and incomplete abstracts can be imported, as long as the information is in NAACCR file format.

To import an abstracts or file of abstracts in NAACCR file format, complete these steps:

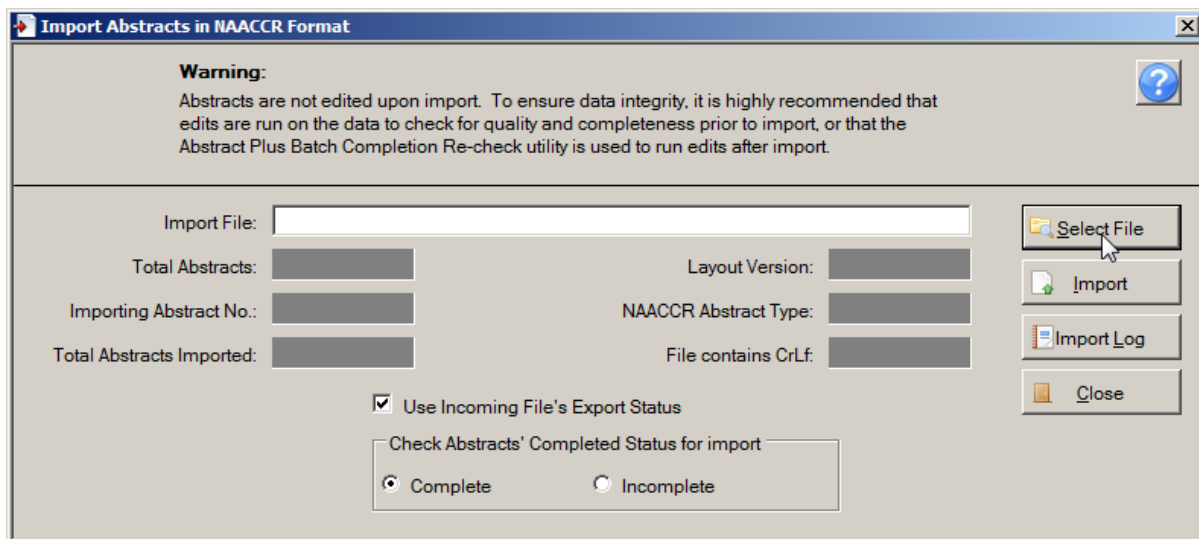
1. Open the Import Abstracts window. This can be done in 3 ways:

- a. Click on the **File** menu, and select **Import Abstracts in NAACCR Format**.



- b. Click the Import icon on the tool bar .
- c. Use the keystroke **Ctrl+L**.

Result: The **Import Abstracts in NAACCR Format** window opens.



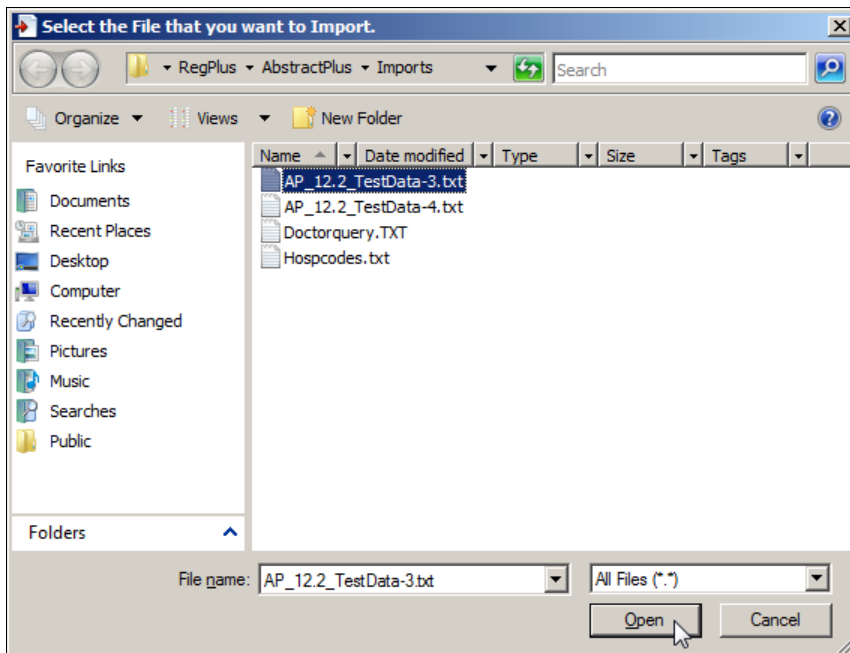
The Import Abstracts function in Abstract Plus 3.3.1.2, NAACCR v13.0-based software allows you to import NAACCR-format Version 12.2 or 13.0 abstract records of NAACCR Record Types I, C, A, or M. Any records in NAACCR version 12.2 will be converted to NAACCR version 13.0 prior to importing, and Collaborative Staging will be re-derived. The import function also performs a basic structural check for record size and version number before importing the abstracts. The system will verify that the file contains valid NAACCR records and will display a record count and other information about the file.

The Import Abstracts window includes these fields and options:

Field/Option	Description
Import File	The name and location of the file of abstracts in NAACCR file format to be imported (click Select File to identify file for import)
Total Abstracts	The total number of abstracts included in the file to be imported
Importing Abstract No.	While importing, this field displays the sequential number of the abstract currently being imported
Total Abstracts Imported	While importing and upon completion of import, this field displays the total number of abstracts imported
Layout Version	The NAACCR Record Version [item #50]of the file to be imported
NAACCR Abstract Type	The NAACCR Record Type [item # 10] of the abstracts in the file to be imported
File contains CtrlLf	The import file may or may not contain Carriage Return, Line Feed characters after each abstract; this field informs you as to whether it does or not
Use Incoming File's Export Status	Option to use the export status included in the import file; when checked, Abstract Plus will check the field of Date Case Report Exported [item #2110]---if the Date Case Report Exported is filled, the incoming abstract will be marked as exported within Abstract Plus
Check Abstracts' completed Status for import	Option to set the Completion Status of the imported abstracts to Complete or Incomplete

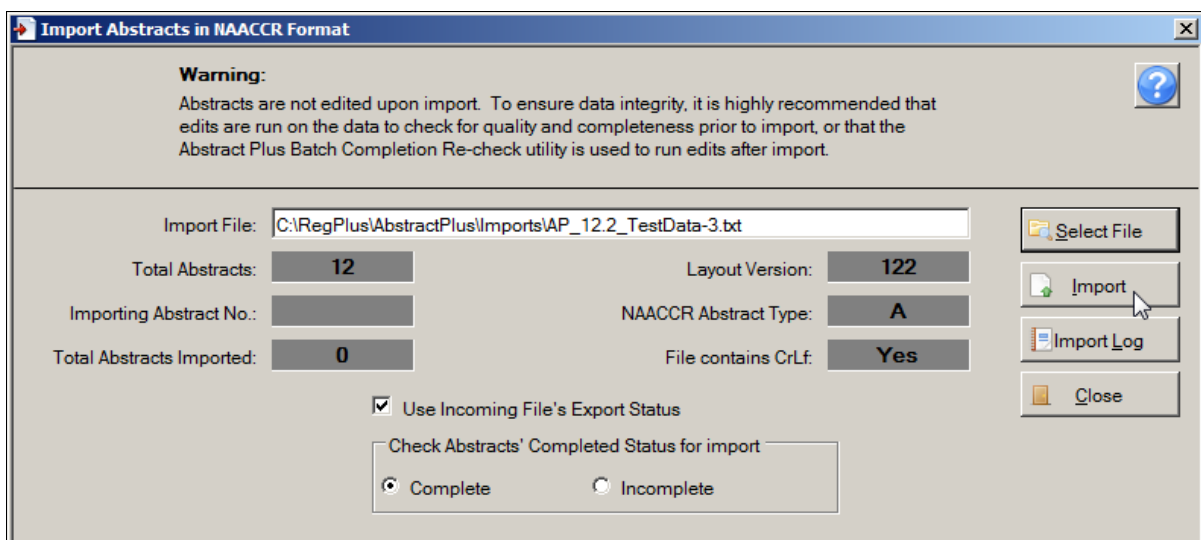
- Click **Select File** to navigate to the file to be imported on your computer or network.

Result: The **Select File** window opens defaulted to the C:\RegPlus\AbstractPlus\Imports folder.



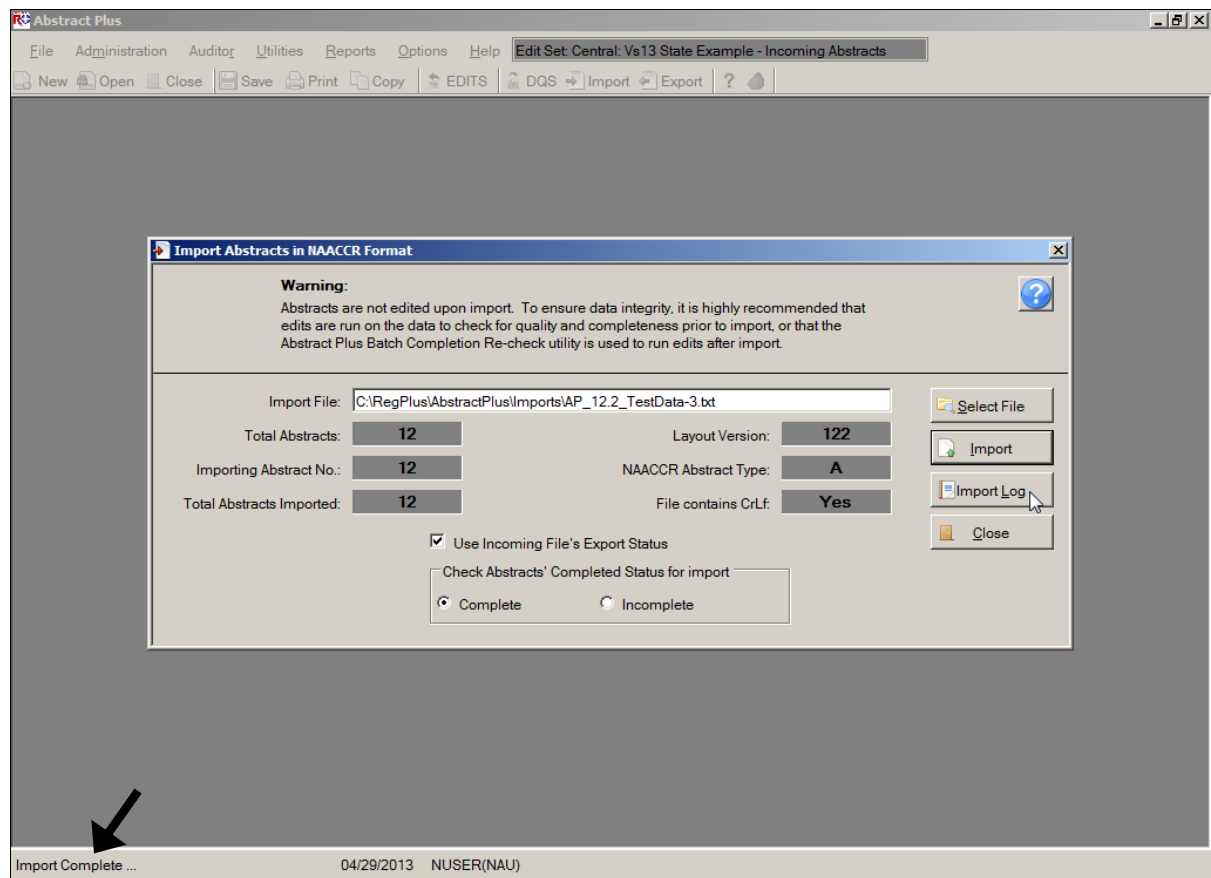
3. **Select the file** of abstracts in NAACCR file format that you would like to import, and click **Open**. In the example shown, the file being selected and imported is named **AP_12.2_TestData-3.txt**.

Result: You are returned to the Import Abstracts window, where preliminary information is displayed about the file selected for import, such as the number of abstracts in the file and the NAACCR abstract type. In the example shown, the AP_12.2_TestData-3.txt file includes 12 abstracts of Record Type A in NAACCR Record Version 12.2 (122), and contains Carriage Return and or Line Feed characters after each abstract.



4. Specify the **Completion Status** (complete or incomplete) that you would like to assign to all abstracts in the imported file, and specify whether you would like to use the **export status** of the abstracts in the incoming file. Click **Import**. In the example shown, the default option of Complete is left selected, as well as **Use Incoming File's Export Status**.

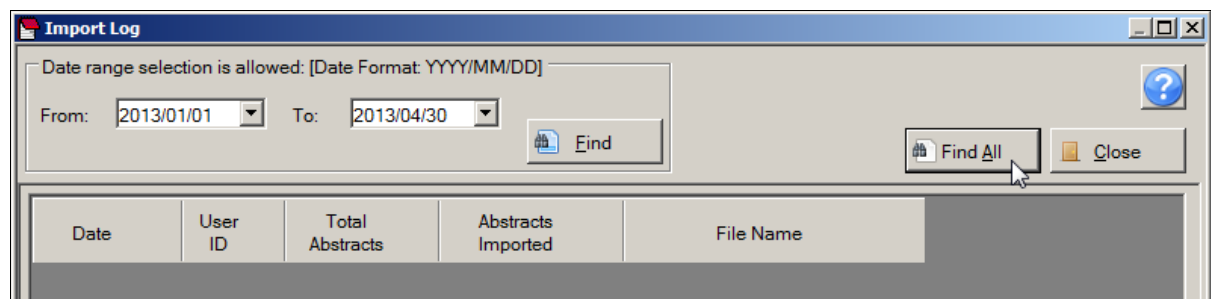
Result: The abstracts in the import file are imported into Abstract Plus. When the import is complete, the application lets you know by stating “Import Complete...” on the status bar in the lower left-hand corner of the window.



Notice the Import Log button on this window. Clicking **Import Log** opens the Import Log window, where you can view the history of the abstracts imports.

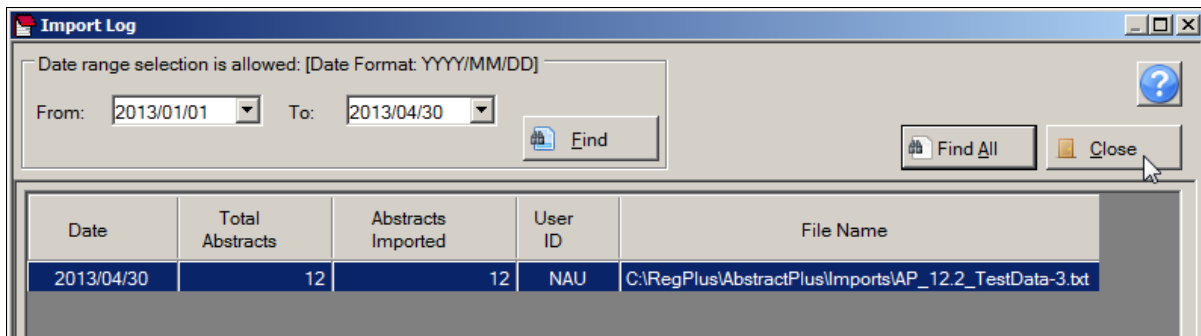
5. Click **Import Log**.

Result: The **Import Log** window opens.



6. Enter either a desired export **date range** or click **Find All**.

Result: The system displays information about the data that has been imported: the date the file was imported, the number of abstracts in the file, the number of abstracts imported, the name of the abstractor that imported the abstracts, and the imported file name.



7. Click **Close** to close the Import Log, and **Close** again to close the Import window.

The Abstract Plus Abstracting Window

As mentioned, Abstract Plus has been entirely reprogrammed using .NET technology, and has an extremely user-friendly abstracting interface. Direct grid entry of coded values and quick select options for pull-down menus allow for an easy, streamlined abstracting experience, as well as easier viewing of text fields, online help, and edit errors.

The Abstract Plus Abstracting window is divided into 2 main sections: a data entry grid for coded values on the left, and a data entry grid for text fields on the right. When you left-click and hold your mouse on the vertical divider bar in the center of the window, a splitter is highlighted which you can drag to the left or right to resize the view of codes or text fields, and the application remembers your last placement of the divider bar. You can vertically scroll the view of coded values and text fields independently to easily and concurrently view codes and associated text.

The screenshot shows the Abstract Plus software interface. The title bar reads "Abstract Plus - [AbsRefID: 0]". The menu bar includes File, Administration, Auditor, Utilities, Reports, Options, and Help. The toolbar contains icons for New, Open, Close, Save, Print, Copy, EDITS, DQS, Import, and Export. The main window is divided into several sections:

- Section Headers:** Includes "Unsaved Abstract", "Abstract Sections", and "Display Types".
- Custom Data Item Labels:** A list of fields on the left side, including Name-Last, Name-First, Name-Middle, Name-Maiden, Name-Alias, Social Security Number, Address fields (DX-No Street, DX-Supplemental, DX-City, DX-State, DX-Postal Code), County at DX, Race 1-5, and Spanish/Hispanic Origin.
- Direct Grid Entry:** A callout pointing to the Social Security Number field.
- Right-click Any Field for Help and Edit Errors:** A callout pointing to a field in the demographic section.
- Optionally Show Field Messages:** A callout pointing to the "Show Field Messages" checkbox.
- Easy, Direct Access to Text Fields:** A callout pointing to the "Physical Examination" section.
- Can Resize Panes:** A callout pointing to the "Scopes (Endoscopic Examinations)" section.
- Completion Status:** A callout pointing to the "Completion Status" indicator at the bottom.
- Edit Error Count:** A callout pointing to the "EDITS (Error Count = 0)" indicator at the bottom.

The status bar at the bottom shows "Ready ...", "EDITS (Error Count = 0)", "Completion Status: No", "04/24/2013", and "NUSER(NAU)".

Recall that the basic process of generating and updating an abstract is as follows:

- Create the abstract with the patient's identifiers, such as name and social security number and save. After you create an abstract, you can save it at any time and return to your work at a later time.
- Enter codes and text in the in the data entry fields. Save the abstract to retain the information you have entered.
- Correct errors. Each time you open or save the abstract, Abstract Plus can automatically edit the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.
- After you have entered all your data and corrected all errors, the system saves your new abstract as complete. You will see the edits error count and completion status indicators at the bottom of the abstracting window turn from red to green, indicating that the abstract is complete.

The Abstractor uses the following abstracting features of the abstracting window to enter information regarding the patient and tumor being abstracted:

- Many data items offer **code selection from drop-down lists**. In addition, the drop-down lists feature an auto-complete, **find-as-you-type** function that allows the user to type in the first letter, or first few letters, of the desired code label, and the application auto-selects the first item in the list beginning with that letter. In the example shown below, an A has been typed into the Race 1 field, and the application auto-selects the value of American Indian, Aleutian, or Eskimo:

Addr at DX--Postal Code

Race 1

Race 2

Race 3

Race 4

Race 5

Spanish/Hispanic Origin

03 - American Indian, Aleut

03 - American Indian, Aleutian, or Eskimo

04 - Chinese

05 - Japanese

06 - Filipino

07 - Hawaiian

08 - Korean

09 - Asian Indian, Pakistani

10 - Vietnamese

OP/Surgical Proce

Cytolog



Tip

If you begin typing in the data item, but find you need to revise what you have typed, press the backspace key to delete what you have already entered and start typing again. This enables the find-as-you-type feature to automatically find your revised entry.

- b. For data items with extensive listing of coded values, such as primary site, there is lookup assisted data entry with an **advanced search feature**. You can either enter the code directly if known, or click on the **magnifying glass icon** to the left of the data item (**or press F4**) to use the search feature:

Age at Diagnosis

Primary Site

Laterality

Histologic Type ICD-O-3

Enter a full or partial search term or code to search for, and then double-click on the code of your choice to transfer the value to the data item in the data entry grid.

Code Lookup for Primary Site

Enter a value to search for Primary Site

Search

PROS

CODE	DESCRIPTION
C619	Gland, prostate
C619	Prostate gland
C619	Prostate, NOS
C680	Prostatic utricle
C680	Utricle, prostatic

- c. The system preferences have been determined by the MCSP. The system will **automatically calculate Age at Diagnosis** once date of birth and diagnosis are entered. The automatic calculate option for Collaborative Stage has not been set by the MCSP. To derive the staging fields, once the appropriate CS input fields have been entered, place the cursor into any of the derived fields and press **F5** or **click the calculator icon** to the left of the field.

Derived SS2000

Derived SS2000--Flag



The default display system preferences for Display Fields, Critical Fields, Edits Configuration, Individual Edits and CS Calculations have been pre-established by the MCSP. Do NOT make any changes to the pre-established system preferences

- d. Depending on the system preferences set by your Abstract Plus Administrator, if the address at diagnosis is the same as the current address for a patient, users can **automatically copy the values in all address at diagnosis data items to the current address fields by pressing F5** when the cursor is located in the **Addr Current—No Street data item:**

Upon pressing the F5 key the address at diagnosis values get copied over to the current address fields:

- e. If the coded values for certain Rx Summ treatment data items are determined to be the same as the associated Rx Hosp data items, the value in a particular Rx Hosp data item **can automatically copied over to the associated Rx Summ data item by pressing F5** while the cursor is still in the Rx Hosp Data item:

Upon pressing the F5 key the Rx Hosp value gets copied over to the Rx Summ data item:

RX Hosp--Surg Prim Site	<input type="text" value="20"/>
RX Summ--Surg Prim Site	<input type="text" value="20"/>

Below is a list of Rx Hosp treatment data items that Abstract Plus offers the ability to be mapped to their associated Rx Summ data item:

NAACCR Item No	Hosp Rx Data Item Name	NAACCR Item No	Rx Summ Data Item Name
670	RX Hosp--Surg Prim Site	1290	RX Summ--Surg Prim Site
672	RX Hosp--Scope Reg LN Sur	1292	RX Summ--Scope Reg LN Sur
674	RX Hosp--Surg Oth Reg/Dis	1294	RX Summ--Surg Oth Reg/Dis
676	RX Hosp--Reg LN Removed	1296	RX Summ--Reg LN Examined
690	RX Hosp--Radiation	1360	RX Summ--Radiation
700	RX Hosp--Chemo	1390	RX Summ--Chemo
710	RX Hosp--Hormone	1400	RX Summ--Hormone
720	RX Hosp--BRM	1410	RX Summ--BRM
730	RX Hosp--Other	1420	RX Summ--Other
740	RX Hosp--DX/Stg Proc	1350	RX Summ--DX/Stg Proc
3280	RX Hosp--Palliative Proc	3270	RX Summ--Palliative Proc
746	RX Hosp--Surg Site 98-02	1646	RX Summ--Surg Site 98-02
747	RX Hosp--Scope Reg 98-02	1647	RX Summ--Scope Reg 98-02
748	RX Hosp--Surg Oth 98-02	1648	RX Summ--Surg Oth 98-02

- f. **Prompt messages** may be associated with each data item, so that when the abstractor clicks into the field, a pop-up box comes up with a message or instructions about abstracting that field:

- g. When entering text, a **progress bar** is displayed below each text field indicating how much space is left so that you can properly prioritize the information you are entering:

- h. **Keyboard and mouse alternatives** are now available for every function in the software. Note that Keystroke options are displayed on menus for all menu items, and [Appendix A](#) of this training manual contains a listing of standard Abstract Plus keyboard shortcuts to functions.
- i. All-new **right-click functions** for individual data items, including access to field context help, edits error information, field messages, and a function to clear all Collaborative Stage fields:

Undo	Ctrl+Z
Cut	Ctrl+X
Copy	Ctrl+C
Paste	Ctrl+V
Delete	Alt+D
Select All	Alt+A
Field Context Help	F1
Edits Information	F2
Field Message	F3
Run EDITS	F8
Clear Collaborative Stage Fields	F9

- j. **Color-coded edits error count and abstract completion status** information is clearly displayed to the user at the bottom of the abstracting window, and changes from red to green upon completion of the abstract:

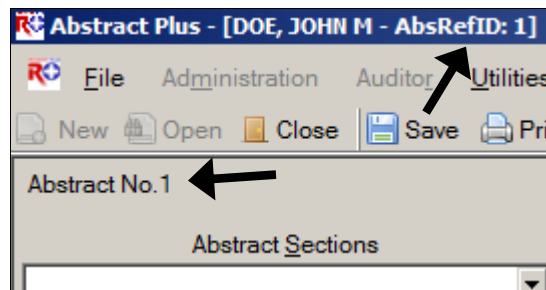
Incomplete abstract containing edit errors:

EDITS (Error Count =2)	Completion Status: No	09/29/2009	NUSER(NAU)
------------------------	-----------------------	------------	------------

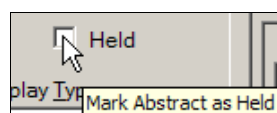
Complete abstract containing no edit errors:

EDITS (Error Count =0)	Completion Status: Yes	09/29/2009	NUSER(NAU)
------------------------	------------------------	------------	------------

- k. **Once saved**, each abstract is assigned a unique **Abstract Reference ID** (or AbsRefID), displayed in the upper left-hand corner of the data entry area of abstracting window, as well as in the title bar of the application along with the patient name:



- l. **Abstracts can be held to prevent export.** The **Held** check box allows an abstractor to prevent a case from being exported even if it is considered complete by the system. This can be used if, for example, the abstractor is searching for additional information to be included before the abstract is exported. If checked, the abstract will not be exported, regardless of Completion Status:



Entering Dates in Abstract Plus

As of the NAACCR version 13.0 record layout, all dates are in the YYYYMMDD format. Because the NAACCR standards are so tightly integrated with the Abstract Plus program. Dates are entered in the YYYY/MM/DD format in Abstract Plus.

The Abstractor will enter dates in the new YYYYMMDD format as follows:

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies



Tip

Abstract Plus has a date field entry mask on all date fields that already has the slashes in it. Although the application allows you to type the slashes and dashes when entering dates fields, you can save keystrokes by **only typing the 8 characters of the date**. For example for the date of March 1, 2013, is entered as 20130301.

Abstracting and Deriving Collaborative Staging Fields

Abstract Plus version 3.3.1.2 has some special features to facilitate the abstraction of Collaborative Staging (CS) input fields, in particular for the Site-Specific Factors (SSFs).

Abstracting CS Input Fields

Once the fields for the primary site and histology have been entered, each CS input data item has a special site-specific look-up associated with it. This can be accessed by **clicking the magnifying glass icon** to the left of the field or **pressing F4**.

Abstracting CS SSFs

Abstract Plus allows for automatic defaulting of CS SSFs and the running of edits to identify required CS fields, automatic filling in of CS fields, as well as, the wiping out of CS input fields for cases diagnosed 2003 and earlier.

For the filling of the CS fields, once the Abstractor enters a Primary Site, Histology, DxDate and Behavior (in no particular expected order), the fields of CS Input Current (item #2937) and CS Input Original (item #2935) are both automatically filled **when the Abstractor enters any CS input field**. CS Derived (item #2936) is filled when you derive the CS derived fields.

Once entered, a check on primary site and histology is run to ascertain whether or not SSF25 is required for schema identification.

1. If SSF25 is required for the primary site and histology entered.
 - a. The SSF25 look-up window for the entered schema will open so that you can select a value for SSF25.
 - b. Once you have entered SSF25, automatic defaulting and disabling of SSFs that are undefined for the entered schema will occur. This will enable you to clearly discern what SSFs are not required, and which SSFs are required. The automatic defaulting will delineate what SSFs are not defined for the identified schema, and the running of edits will delineate what SSFs are required.




**Note**

If the primary site and histology initially entered are revised to result in a different schema, you will be offered the option of clearing all CS input fields and re-coding CS for the abstract. Regardless of whether you clear all values and re-code CS, or keep existing values and modify the codes, the above SSF defaulting routine will run again for the newly entered schema.

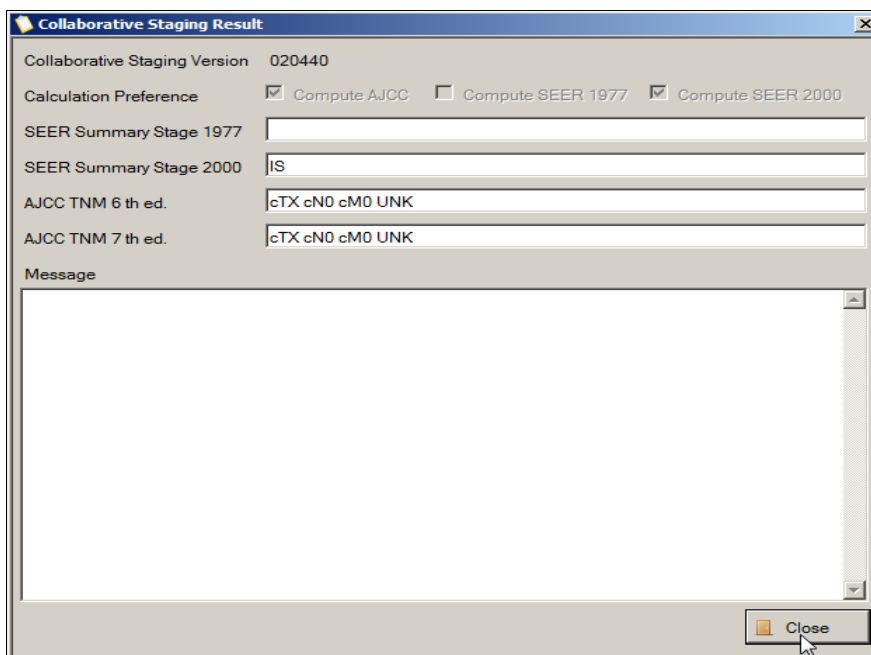
2. If SSF25 is not required for the primary site and histology entered.
 - a. SSF25 will be automatically defaulted and disabled.
 - b. Automatic defaulting and disabling of other SSFs that is undefined for the entered schema will occur. This will enable you to clearly discern what SSFs are not required, and which SSFs are required. The automatic defaulting will delineate what SSFs are not defined for the identified schema, and the running of edits will delineate what SSFs are required.

Calculating Derived Staging Fields

To derive the staging fields, once the appropriate CS input fields have been entered, place the cursor into any of the derived fields and **press F5** or **click the calculator icon** to the left of the field.

CS Site-Specific Factor25		988
Derived SS2000		
Derived SS2000--Flag		
CS Version Input Current		020200
CS Version Input Original		020200
CS Version Derived		

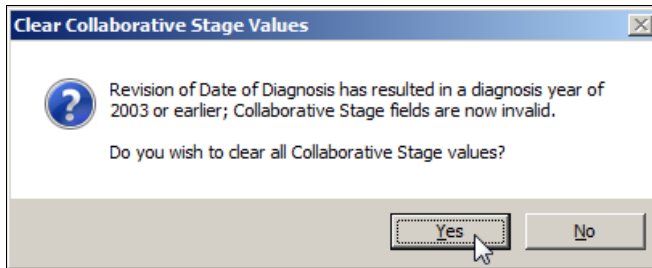
Result: The **Collaborative Staging Result** window open and displays the calculated values.



The screenshot shows the 'Collaborative Staging Result' window. At the top, it displays 'Collaborative Staging Version 020440'. Below this, there are checkboxes for 'Calculation Preference': 'Compute AJCC' (checked), 'Compute SEER 1977' (unchecked), and 'Compute SEER 2000' (checked). The main section contains several text input fields: 'SEER Summary Stage 1977' (empty), 'SEER Summary Stage 2000' (containing 'IS'), 'AJCC TNM 6 th ed.' (containing 'cTX cN0 cM0 UNK'), and 'AJCC TNM 7 th ed.' (containing 'cTX cN0 cM0 UNK'). At the bottom, there is a large empty 'Message' box and a 'Close' button.

CS Fields and Tumors Diagnosed 2003 and Earlier

One further helpful feature is that upon entry of a Date of Diagnosis of 2003 and earlier, you will be offered the option of clearing all CS fields.



The Clear Collaborative Staging Values window opens automatically upon entry of a diagnosis year of less than 2004. However, you can clear Collaborative Staging fields at any time by using the **right-click function** to Clear Collaborative Stage Fields or pressing **F9**.



Tip

<u>U</u> ndo	Ctrl+Z
Cu <u>t</u>	Ctrl+X
<u>C</u> opy	Ctrl+C
<u>P</u> aste	Ctrl+V
<u>D</u> elete	Alt+D
Select <u>A</u> ll	Alt+A
Field Context <u>H</u> elp	F1
Edits <u>I</u> nformation	F2
<u>F</u> ield Message	F3
Run EDITS	F8
Clear Collaborative Stage Fields	F9

Abstracting Histologic Type for Hematopoietic and Lymphoid Neoplasms

Prior to cases diagnosed in 2010, coding of Histologic Type in Abstract Plus entailed using the advanced search feature for the Histologic Type field: click the magnifying glass icon to the left of the field, enter a search term in the search window that opens, and double-click the histologic code that is listed for the specific term for which a search was conducted.

However, new reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms have gone into effect for cases diagnosed beginning January 1, 2010. As a result, two tools have been developed by SEER for use beginning in 2010: The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual, and the Hematopoietic Database. The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual comes within the Hematopoietic Database; contains reportability instructions and rules for determining the number of primaries, the primary site, histology, and tumor grade.

The Hematopoietic DB is a stand-alone application developed to assist in screening for reportable cases and determining reportability requirements, and contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3-9992/3).

The SEER Hematopoietic Database must be independently installed and maintained by the Abstractor. It can be downloaded from the following URL: <http://seer.cancer.gov/tools/heme/>. In order to stay abreast of revisions in the database, it is recommended that you sign up on the website to receive e-mails when the database is updated.



Sign Up for E-mail Updates

If you would like to receive notification via e-mail when new releases of the program become available, please sign up using the form below. Your information will only be used to send you future notices about the Hematopoietic Database.

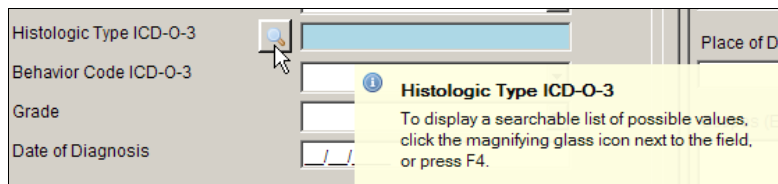
Name:

Email Address (required):

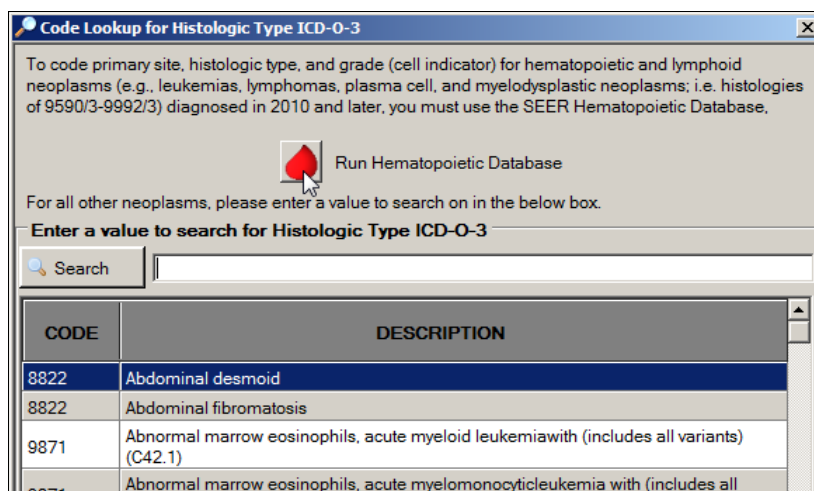
Organization:

Once installed on the same computer on which Abstract Plus is installed, the Hematopoietic Database is minimally integrated into Abstract Plus, and can be launched in the following 3 ways.

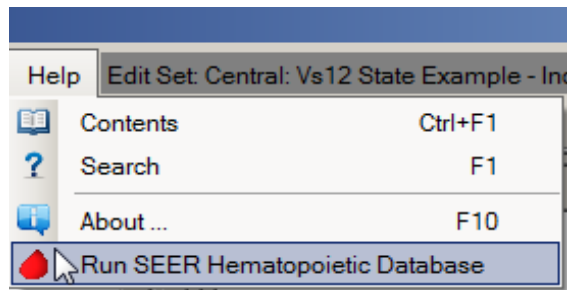
- i. **From the Histology Lookup window:** Click on the **magnifying glass icon** to the left of the Histologic Type ICD-O-3 data item or **press F4** to use the search feature.



Then **click the blood drop icon** to launch the Hematopoietic database.



- ii. Click on the **Help** menu, and select **Run SEER Hematopoietic Database**.



- iii. Click the Hematopoietic Database icon on the tool bar .



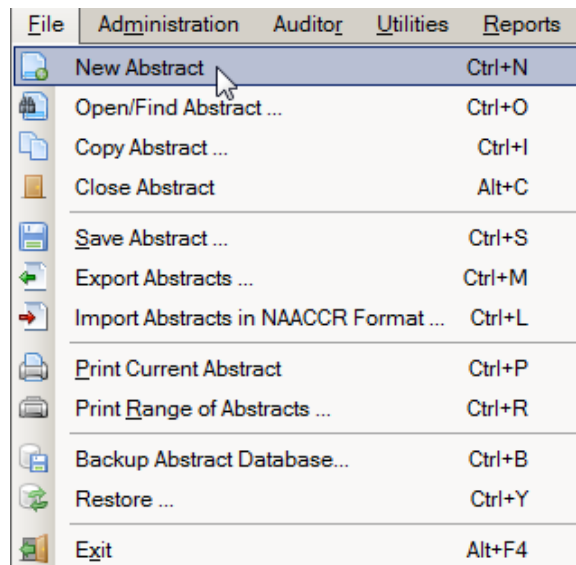
Tip

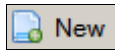
Be sure to follow the steps in the flowchart in [Appendix B](#) when using the Hematopoietic Database and Manual to code hematopoietic and lymphoid neoplasms.

Creating a New Abstract

To create a new abstract, complete these steps:

1. Open the Abstract Plus Abstracting window. This can be done in 3 ways:
 - a. Click on the **File** menu, and select **New Abstract**.



- b. Click the New icon on the tool bar .
 - c. Use the keystroke **Ctrl+N**.

Result: The **Abstract Plus Abstracting Window** opens.

ABSTRACTING - Data Entry Procedure

The following instructions are provided to complete the data entry procedures for each data item. The instructions pertain to both HOSP130 and LAB130 Display Types. Press **Enter** after each data item is entered to move to the next data item/field.

If you are not familiar with the window and features of Abstract Plus version 3.3.1.2 go to Chapter 2: Abstract Plus General User Basics or click [here](#)



Note

Line returns are not allowed in Abstract Plus text fields---pressing Enter will move the cursor to the next text field in the text entry grid.



Tip

If you begin typing in the data item, but find you need to revise what you have typed, press the backspace key to delete what you have already entered, and start typing again. This enables the find-as-you-type feature to automatically find your revised entry.

The Item No. corresponds to the Item Number on the MCSP Cancer Report Form; however, not all Fields have a MCSP Item Number.



Important

The order of the Data Item and Value to be Entered is provided below in the **display field order in Abstract Plus version 3.3.1.2, NAACCR v13.0** instead of the numerical order on the MCSP Cancer Report Form.

ENTERING PATIENT ID INFORMATION

Item No.	Data Item/Field	Value to be Entered
1a.	Name-Last:	<p>Type the legal Last Name of the patient and press Enter.</p> <p>Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed.</p> <p>If the last name is not available, type Unknown.</p> <p>This field may be updated, if the Last Name changes. For information on how to submit corrections, refer to 'Submitting Corrections' in the <i>MCSP Cancer Reporting Manual</i>.</p> <p>Do not leave this data item blank.</p>
1b.	Name-First:	<p>Type the legal First Name of the patient and press Enter.</p> <p>Truncate if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.</p> <p>If the patient's first name is not available, type Unknown.</p> <p>This field may be updated, if the First Name changes. For information on how to submit corrections, refer to 'Submitting Corrections' in the <i>MCSP Cancer Reporting Manual</i>.</p> <p>Do not leave this data item blank.</p>
1c.	Name-Middle:	<p>If known, type the legal Middle Name or Middle Initial of the patient and press Enter.</p> <p>Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.</p> <p>This field may be updated, if the Middle Name changes. For information on how to submit corrections, refer to 'Submitting Corrections' in the <i>MCSP Cancer Reporting Manual</i>.</p> <p>If no middle name or initial, press Enter to move to</p>

Item No.	Data Item/Field	Value to be Entered
		the next field.
	Name-Suffix	Type the Suffix (title) that follows the patient's last name, such as a generation or credential status (e.g., MD, III, Sr., Jr.) and press Enter . If unknown or not reporting, press Enter to move to the next field.
3.	Name-Alias:	Type the Alias (alternate name) or "AKA" (also known as) used by the patient. Note that Maiden Name is entered in Name-Maiden. If unknown or not reporting, press Enter to move to the next field.
2.	Name-Maiden:	Type the Maiden Name of female patients who are or have been married and press Enter . Do not abbreviate. If unknown or not reporting, press Enter to move to the next field.
4.	Social Security Number:	Types the patient's Social Security Number without dashes and without any letter suffix, and press Enter . A patient's Medicare claim number may not always be identical to the patient's Social Security number. Code Social Security numbers that end with "B" or "D" as 999999999. (The patient receives benefits under the spouse's number and this is the spouse's Social Security Number.) If the patient does not have a Social Security number, type 999999999. If the patient's Social Security number is not available, type 999999999. Social Security Number is a REQUIRED data item regardless of facility type . If after review of the patient's hospital charts, outpatient records, other available records, other facility inquiries, or follow-back with the physician on record, the Social Security Number is unknown, type 999999999.

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank.
7.	Date of Birth:	<p>Type the patient's Date of Birth as indicated in the patient record in YYYYMMDD format and press Enter.</p> <p>For <i>in utero</i> diagnosis and treatment, record the actual date of birth. It will follow one or both dates for these events.</p> <p>If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded.</p> <p>Estimate date of birth when information is not available. It is better to estimate than to leave birthdate unknown.</p> <p>If the date of birth cannot be determined at all, leave this data item blank and record the reason in the Date of Birth Flag.</p>
	Date of Birth Flag:	<p>The Date of Birth Flag explains why there is no appropriate value in the corresponding Date of Birth field.</p> <p>Type 12 if the Date of Birth cannot be determined at all.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this data item blank if Date of Birth has a full or partial date recorded.</p>
	Age at Diagnosis:	<p>Leave Age at Diagnosis field blank and press Enter.</p> <p>Age at Diagnosis will be automatically calculated and entered when the Date of Birth and Date of Diagnosis values are entered.</p> <p>Different tumors for the same patient may have different values.</p>

Item No.	Data Item/Field	Value to be Entered
9.	Sex:	<p>Type the Sex code as indicated in the patient record and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>The same sex code should appear in each abstract for a patient with multiple tumors.</p> <p>Do not leave this data item blank.</p>
12.	Marital Status at DX:	<p>Type the Marital Status at DX code as indicated in the patient record at the time of diagnosis and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list and press Enter.</p> <p>If the patient has multiple tumors, the Marital Status at DX may be different for each tumor.</p> <p>If unknown or not reporting, type 9.</p> <p>For display type LAB130, if unknown, leave the default value of 9, and press Enter.</p> <p>Do not leave this data item blank.</p>

ENTERING DEMOGRAPHIC INFORMATION

Item No.	Data Item/Field	Value to be Entered
5a.	Addr at Dx-No Street:	<p>Type the Number and Street address or the rural mailing address of the patient's usual residence at the time the reportable tumor was diagnosed and press Enter.</p> <p>The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S Postal Service postal addressing standards.</p> <p>Punctuation is normally limited to periods (e.g., 39.2 Rd), slashes for fractional addresses (e.g., 101 ½ MAIN ST), and hyphens when a hyphen carries a meaning (e.g., 289-01 MONTGOMERY AVE).</p> <p>Use of the pound sign (#) to designate address units</p>

Item No.	Data Item/Field	Value to be Entered
		<p>should be avoided whenever possible. If a pound is used, there must be a space between the pound sign and the secondary number (e.g., # 72).</p> <p>These standards are referenced in USPS Publication 28, July 2008, <i>Postal Addressing Standards</i>. The current USPS Pub. 28 may be found and downloaded from the following Web Site: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.</p> <p>Canadian addresses should conform to the <i>Canada Postal Guide</i>, last updated January, 2010. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca/tools/pg/manual/default-e.asp</p> <p>Additional address information such as facility, nursing home, or name of apartment complex should be entered in the Addr At DX – Supplementl field.</p> <p>If the patient has multiple tumors, the address may be different for subsequent primaries.</p> <p>Do <u>not</u> update this data item if the patient’s address changes.</p> <p>If the address is unknown, type “Unknown.”</p> <p>Do not leave this data item blank.</p>
5c.	Addr at DX-Supplementl:	<p>Type the additional address information such as place or facility (e.g., a nursing home or name of an apartment complex) of the patient’s usual residence at the time the reportable tumor was diagnosed.</p> <p>Do <u>not</u> update this data item if the patient’s address changes.</p> <p>If not applicable or unknown, leave this data item blank and press Enter.</p>
5b.	Addr at DX-City:	<p>Type the name of the City or Town in which the patient resides at the time the reportable tumor was diagnosed and press Enter.</p> <p>If the patient has multiple tumors, the city or town</p>

Item No.	Data Item/Field	Value to be Entered
		<p>may be different for subsequent primaries.</p> <p>Do not update this data item if the patient's address changes.</p> <p>Do not leave this data item blank.</p>
5d.	Addr at DX-State:	<p>If the U.S. Postal abbreviation for the state in which the patient resides at the time the reportable tumor was diagnosed is Michigan, leave the preset default value and press Enter.</p> <p>To display a searchable list of possible values, use the drop down box to locate the value. You may need to use the scroll bar to display additional values. Double click on the appropriate code and press Enter.</p> <p>If the residence is unknown, press the backspace key to delete the default value of MI - Michigan. Type Z and select ZZ – Residence Unknown and, press Enter.</p> <p>If the patient has multiple tumors, the state of residence may be different for each tumor.</p> <p>Do not leave this data item blank.</p>
5e.	Addr at DX-Postal Code:	<p>Type the patient's extended Postal Code at the time of diagnosis and treatment and press Enter.</p> <p>If the extended zip code is not available, type the five-digit zip code. (Blanks follow the 5-digit code).</p> <p>For Canadian residents, record the six-character postal code.</p> <p>When available, record the postal code for other countries.</p> <p>Not US, not Canada, postal code unknown, type 8888888888.</p> <p>US/Canada, postal code unknown; OR residence unknown, type 9999999999.</p> <p>If the patient has multiple tumors, the postal code</p>

Item No.	Data Item/Field	Value to be Entered
		<p>may be different for subsequent primaries.</p> <p>Do not update this data item if the patient's postal code changes.</p> <p>Do not leave this data item blank.</p>
6a.	County at DX:	<p>To display a searchable list of possible values for Country at the time the reportable tumor was diagnosed, click on the magnifying glass icon next to the field or press the F4 key and a Lookup window will appear.</p> <p>Type the name of the County in the search box or use the scroll bar to locate the value. Double click on the value and press Enter.</p> <p>If unknown County, type 999.</p> <p>If out-of-state County is not available, Non-US resident, type 999.</p> <p>Code 998 is not an allowable value in Abstract Plus Version 3.3.1.2.</p> <p>Do not leave this data item blank.</p>
6b.	Addr at DX - Country	<p>If the Country at the time the reportable tumor was diagnosed is USA, leave the default value and press Enter.</p> <p>To display a searchable list of possible values, click the magnifying glass icon next to the field or press the F4 key and a Lookup window will appear. Type the name of the Country in the search box or use the scroll bar to locate the value. Double click on the value and press Enter.</p> <p>If the patient has multiple tumors, the country of residence may be different for each tumor.</p> <p>If the Country is not the United States and Country is unknown, type ZZU (unknown).</p> <p>Do not leave this data item blank.</p>

Item No.	Data Item/Field	Value to be Entered
6c.	Addr Current – No Street	<p>Type the number and street address or the rural mailing address of the patient's current usual residence and press Enter.</p> <p>This data item provides a current address used for follow-up purposes. It may or may not be different than the patient's address at the initial time of diagnosis.</p> <p>Additional address information such as facility, nursing home, or name of apartment complex should be entered in Addr Current-Supplementl field.</p> <p>The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S Postal Service postal addressing standards.</p> <p>Punctuation is normally limited to periods (e.g., 39.2 Rd), slashes for fractional addresses (e.g., 101 ½ MAIN ST), and hyphens when a hyphen carries a meaning (e.g., 289-01 MONTGOMERY AVE).</p> <p>Use of the pound sign (#) to designate address units should be avoided whenever possible. If a pound is used, there must be a space between the pound sign and the secondary number (e.g., # 72).</p> <p>U.S. addresses should conform to the U.S. Postal Service (USPS) <i>Postal Addressing Standards</i>. These standards are referenced in USPS Publication 28, July 2008, <i>Postal Addressing Standards</i>. The current USPS Pub. 28 may be found and downloaded from the following Web Site: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.</p> <p>Canadian addresses should conform to the <i>Canada Postal Guide</i>, last updated January, 2010. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca/tools/pg/manual/default-e.asp</p> <p>If the patient has multiple tumors, the current address must be the same for all tumors.</p> <p>If the address is unknown, type "Unknown."</p>

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank.
	Addr Current - Supplementl	<p>Type the place or facility (e.g., a nursing home or name of an apartment complex) of the patient's <u>current</u> usual residence.</p> <p>If the patient has multiple tumors, the current city of residence should be the same for all tumors.</p> <p>If not applicable or unknown, leave this data item blank and press Enter.</p>
	Addr Current - City	<p>Type the name of the City or Town of the patient's <u>current</u> usual residence and press Enter.</p> <p>If the patient has multiple tumors, the current city of residence should be the same for all tumors.</p> <p>Do not leave this data item blank.</p>
	Addr Current - State	<p>If the State of the patient's <u>current</u> usual residence is Michigan, leave the preset value and press Enter.</p> <p>To display a searchable list of possible choices, press the backspace key to delete the value of Michigan. Select the appropriate value and press Enter.</p> <p>If unknown, Type Z and select ZZ – State Unknown and press Enter.</p> <p>If the patient has multiple tumors, the current state of residence should be the same for all tumors.</p> <p>Do not leave this data item blank.</p>
	Addr Current – Postal Code	<p>Type the patient's extended Postal Code of the patient's <u>current</u> usual residence and press Enter.</p> <p>If the extended zip code is not available, type the five-digit zip code. (Blanks follow the 5-digit code).</p> <p>For Canadian residents, record the six-character postal code.</p> <p>When available, record the postal code for other countries.</p>

Item No.	Data Item/Field	Value to be Entered
		<p>Not US, not Canada, postal code unknown, type 8888888888.</p> <p>US/Canada, postal code unknown; OR residence unknown, type 9999999999.</p> <p>If the patient has multiple tumors, the postal code of the patient's current residence must be the same for all tumors.</p> <p>Do not leave this data item blank.</p>
	Addr Current - Country	<p>If the <u>current</u> Country is USA leave the preset default value and press Enter.</p> <p>To display a searchable list of possible values, click the magnifying glass icon next to the field or press the F4 key and a Lookup window will appear. Type the name of the Country in the search box or use the scroll bar to locate the value. Double click on the value and press Enter.</p> <p>If the patient has multiple tumors, the <u>current</u> Country of residence must be the same for each tumor.</p> <p>If the current Country is unknown AND not USA, type ZZU (unknown).</p> <p>Do not leave this data item blank.</p>
8.	Birthplace:	<p>Revised for 2013: The former <i>Place of Birth</i> is replaced with <i>Birthplace-State</i> (NAACCR Item #252), and some applicable codes have changed.</p> <p>If unknown or not reporting, leave the preset default value of 999 and press Enter.</p> <p>NOTE: If the Birthplace-State, Birthplace-Country is NOT coded as unknown, Birthplace must be either be left blank (remove preset default value) or the value must be coded for the USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born.</p> <p>To display a searchable list of possible values, click</p>

Item No.	Data Item/Field	Value to be Entered
		<p>the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Type the name of the birthplace in the search box. You may need to use the scroll bar to display additional values. Double click on the value and press Enter.</p> <p>Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries.</p> <p>For SEER Geocodes, see the most recent <i>Standards for Cancer Registries Volume II: Data Standards and Data Dictionary</i> at http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx</p>
8a.	Birthplace-State	<p>If unknown or not reporting, leave the preset default value of ZZ (Unknown if U.S., Canada, or other country) and press Enter.</p> <p>To display a searchable list of possible values, use the drop down box to locate the value. You may need to use the scroll bar to display additional values. Double click on the appropriate code and press Enter.</p> <p>Code the USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. For example, if the state in which the patient was born is Michigan, use the USPS (MI) for the state of Michigan.</p> <p>If the patient has multiple primaries, the state of birth is the same for each tumor.</p> <p>This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes.</p> <p>It supplements the item Birthplace–Country, and these data items are intended to replace the data item Birthplace.</p> <p>For more information on numeric and alphabetical lists of places and codes, refer to Appendix B of the</p>

Item No.	Data Item/Field	Value to be Entered
		SEER Program Code Manual at http://seer.cancer.gov/tools/codingmanuals/index.html
		Do not leave this data blank.
8b.	Birthplace-Country	<p>If unknown or not reporting, leave the preset default value of ZZU (Unknown) and press Enter.</p> <p>To display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Type the name of the Birthplace-Country in the search box. You may need to use the scroll bar to display additional values. Double click on the value and press Enter.</p> <p>If the patient has multiple tumors, all records should contain the same code.</p> <p>This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes.</p> <p>It supplements the item Birthplace-State, and these two items are intended to replace the data item Birthplace.</p> <p>Do not leave this data blank.</p>
11.	Race 1:	<p>Type the Race code according to the documentation in the patient's medical record and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Race is a required data item regardless of facility type. If the race is not documented in the patient's medical record, outpatient records, other available records; such as laboratory specimen form, inquiries with other facilities or the physician on record <u>must</u> be conducted to obtain this information.</p> <p>ALL tumors for the same patient <u>must</u> have the same race code(s).</p>

Item No.	Data Item/Field	Value to be Entered
		<p>Do not leave this data blank.</p> <p>If the patient is multi-racial, code all races using <i>Race 2</i> through <i>Race 5</i>. If no further race is documented, record race as 88.</p> <p>If the person is multiracial and one of the races is white, code the other race code(s) first with white in the next race field.</p> <p>If the person is multiracial and one of the races is Hawaiian, code Hawaiian as Race 1, followed by the other race code(s).</p> <p>For more information on Race coding instructions/requirements, refer to the <i>MCSP Cancer Reporting Manual</i>.</p> <p>Do not leave these data items blank.</p>
10.	Spanish/Hispanic Origin:	<p>Type the Spanish/Hispanic Origin code and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Code identifying persons of Spanish or Hispanic origin. This code is used by hospital and central registries to show the "best guess" as to whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. If the patient has multiple tumors, all records should have the same code.</p> <p>Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf</p> <p>All information resources should be used to determine the correct code, including:</p> <ul style="list-style-type: none"> • Stated ethnicity in the medical record • Stated Hispanic origin on the death certificate • Birthplace

Item No.	Data Item/Field	Value to be Entered
		<ul style="list-style-type: none"> Information about life history and/or language spoken found during the abstracting process Patient's last name or maiden name <p>Some registries code the information from the medical record, others code ethnicity based on Spanish names, and others use a combination of methods.</p> <p>Persons of Spanish or Hispanic origin may be of any race, but these categories generally are not used for Native Americans, Filipinos, etc., who may have Spanish names. If a patient has a Hispanic name, but there is reason to believe they are not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be '0 – non-Spanish, non-Hispanic. The code in the computed ethnicity; however, would reflect the Hispanic name.</p> <p>Assign code 7 if Hispanic ethnicity is based strictly on a computer list or algorithm (unless contrary evidence is available) and also code in computed ethnicity.</p> <p>NAACCR recognizes that available definitions and abstracting instructions for the Name-Last and Name-Maiden may be inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or "De." Order of names, use of maternal and paternal names, and use of hyphens can vary across cultures. It is likely that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind when using the data.</p> <p>Do not leave this data blank.</p>

ENTERING HOSPITAL SPECIFIC INFORMATION

Item No.	Data Item/Field	Value to be Entered
19.	Medical Record Number:	<p>Type the number that represents the patient's permanent Medical Record Number at the reporting facility and press Enter.</p> <p>If the number is unknown, type Unknown.</p> <p>If not reporting, leave the default value (unknown) and press Enter.</p> <p>Do not leave this data item blank.</p>
20.	M17 Laboratory Number:	<p>Type the number that represents the patient's Laboratory Number at the reporting facility and press Enter.</p> <p>If unknown, type Unknown.</p> <p>If not reporting, leave the default value (Unknown) and press Enter.</p> <p>Do not leave this data item blank.</p>
24.	Reporting Facility:	<p>Type the number of the Reporting Facility and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. In the search box, type the state name and city followed by the facility name. Double click on the appropriate facility number or highlight and press Enter. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
22.	Type of Reporting Source:	<p>Type the Reporting Source code and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>For LAB130 Display Type, the next required data item is Class of Case.</p> <p>Do not leave this data item blank.</p>

Item No.	Data Item/Field	Value to be Entered
29.	Date of 1st Contact:	<p>Type the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course of treatment for this reportable tumor, and press Enter.</p> <p>The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital and press Enter.</p> <p>For analytic cases (Class of Case 00-22), the Date of First Contact is the date the patient (case) became analytic.</p> <p>For non-analytic cases, it is the date the patient first qualified for the Class of Case that causes the case to be abstracted.</p> <p>When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.</p> <p>If this is an autopsy-only or death certificate-only case, then use the date of death.</p> <p>Do not leave any part of this data item blank.</p>
	Date of 1st Contact Flag:	<p>Type the code that explains why there is no appropriate value in the corresponding date field, Date of 1st Contact and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this data item blank if there is a valid date in Date of 1st Contact.</p>
27a.	Date of Inpatient Adm:	<p>Type the date of the Inpatient Admission to the reporting facility for the most definitive surgery in the YYYYMMDD format and press Enter.</p> <p>In the absence of surgery, use date of inpatient admission for any other cancer-directed therapy. In the absence of cancer-directed therapy, use date of inpatient admission for diagnostic evaluation.</p> <p>If unknown or not applicable, leave this data item</p>

Item No.	Data Item/Field	Value to be Entered
		blank and press Enter .
27b.	Date of Inpt Adm Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding Date of Inpatient Admission field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this data item blank if there is a valid date in Date of Inpatient Admission.</p>
28a.	Date of Inpatient Disch:	<p>Type the Date of Inpatient Discharge from the facility after the most recent definitive surgery in the YYYYMMDD format and press Enter.</p> <p>In the absence of surgery, use date of inpatient discharge for other cancer-directed therapy. In the absence of cancer-directed therapy, use the date of inpatient discharge for diagnostic evaluation. This discharge date corresponds to the admission date described in the Inpatient Admission Date field.</p> <p>If unknown or not applicable, leave this data item blank and press Enter.</p>
28b.	Date of Inpt Disch Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding Date of Inpatient Discharge field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this data item blank if there is a valid date value in Date of Inpatient Discharge.</p>
26.	Class of Case:	<p>Type the Class of Case code and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Class of Case is a required data item regardless of facility type.</p> <p>For MI display type LAB130 leave the preset value and press Enter.</p>

Item No.	Data Item/Field	Value to be Entered
Do not leave this data item blank.		
21.	Accession Number-Hosp:	<p>The Accession Number is ONLY required for Hospitals with a Registry, in which case, the number would be assigned as the patient is enrolled into the system.</p> <p>The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.</p> <p>If reporting, type the Hospital Accession Number (4-digit year followed by the 5-digit accession number) and press Enter. There cannot be any blanks in the middle of the accession number.</p> <p>When a patient is deleted from the database, do <u>not</u> reuse the accession number for another patient.</p> <p>Numeric gaps are allowed in accession numbers. (A patient's accession number is never reassigned.)</p> <p>If not reporting, leave the preset default code and press Enter.</p>
21.	Sequence Number-Hosp:	<p>Type the Sequence Number and press Enter. (You cannot double click on the Allowable Values in the pull-down list.)</p> <p>Sequence Number is a required data item for Hospital with a Registry and Hospital without a Registry.</p> <p>Codes 00-59 and 99 indicate reportable neoplasms of <i>in situ</i> or malignant behavior (Behavior Code ICD-O-3 equals 2 or 3).</p> <p>Codes 60-88 indicate neoplasms of non-malignant behavior (Behavior Code ICD-O-3 equals 0 or 1).</p> <p>Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or <i>in situ</i> primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.</p> <p>Code 60 only if the patient has a single non-</p>

Item No.	Data Item/Field	Value to be Entered
13.	Primary Payer at DX:	<p data-bbox="800 243 1479 386">malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.</p> <p data-bbox="800 428 1419 529">If not reporting, the sequence number for unspecified number of non-malignant tumor is recorded as 88.</p> <p data-bbox="800 571 1373 672">If not reporting, the sequence number for unspecified number of malignant tumor, or unknown is recorded as 99.</p> <p data-bbox="800 714 1479 823">For more information, refer to coding instructions for Sequence Number in the <i>MCSP Cancer Program Manual</i>.</p> <p data-bbox="800 865 1256 894">Do not leave this data item blank.</p> <p data-bbox="800 936 1435 1045">Type the Primary Payer at Diagnosis code at the time of diagnosis if the patient is diagnosed at the reporting facility and press Enter.</p> <p data-bbox="800 1087 1458 1188">If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.</p> <p data-bbox="800 1230 1367 1297">Record the type of insurance reported on the patient's admission page.</p> <p data-bbox="800 1339 1398 1407">Codes 21 and 65–68 are to be used for patients diagnosed on or after January 1, 2006.</p> <p data-bbox="800 1449 1455 1516">If more than one payer or insurance carrier is listed on the patient's admission page record the first.</p> <p data-bbox="800 1558 1438 1667">If the patient is not insured at the time of initial diagnosis, record Primary Payer at DX as 01 (Not Insured).</p> <p data-bbox="800 1709 1479 1776">If the patient's payer or insurance carrier changes, do not change the initially recorded code.</p> <p data-bbox="800 1818 1455 1885">If the Insurance status is unknown or not reporting, type 99.</p> <p data-bbox="800 1927 1256 1957">Do not leave this data item blank.</p>

Item No.	Data Item/Field	Value to be Entered
106.	Abstracted By:	<p>When you log into Abstract Plus, your alphanumeric code assigned by the reporting facility at the time of creating a User Account will automatically be displayed in the Abstracted By field.</p> <p>Press Enter to move to the next field.</p>

ENTERING HOSPITAL CONFIDENTIAL INFORMATION

Item No.	Data Item/Field	Value to be Entered
15a.	Text-Usual Occupation:	<p>Type the Usual Occupation of the patient and press Enter. “Usual Occupation” is the kind of work performed during most of the patient’s working life before diagnosis of this cancer/reportable condition.</p> <p>Do <u>not</u> record “retired.”</p> <p>If the Usual Occupation is not available or is unknown, record the patient’s current or most recent occupation, or any available occupation.</p> <p>Do <u>not</u> include descriptive terms with the Usual Occupation such as “longest,” “current,” “last 10 years,” etc.</p> <p>If no information is available, or not reporting, type Unknown.</p> <p>For more information, refer to <i>A Cancer Registrar's Guide to Collecting Industry and Occupation</i> to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.</p> <p>Do not leave this data item blank.</p>
15b.	Text-Usual Industry:	<p>Type the Usual Industry of the patient and press Enter.</p> <p>Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among “manufacturing,” “wholesale,” “retail,” and</p>

Item No.	Data Item/Field	Value to be Entered
16a-c.	MI20 Family Hist Cancer:	<p>“service” components of an industry that performs more than one of these components.</p>
		<p>If the primary activity carried on at the location where the patient worked is unknown, but the name of the company is known, type the company name along with the city or town in which the patient performed his/her Usual Industry.</p>
		<p>Do not record “retired.”</p>
		<p>Do not include descriptive terms with the Usual Industry, such as “retired,” or “not documented,” “or longest worked” etc.</p>
		<p>For more information, refer to <i>A Cancer Registrar's Guide to Collecting Industry and Occupation</i> to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.</p>
		<p>If no information is available or not reporting, type Unknown.</p>
		<p>Do not leave this data item blank.</p>
		<p>Type whether or not the patient has a Family History of Cancer by using the pull-down list provided. Select appropriate value and press Enter.</p>
		<p>An “Immediate Family Member” would be a: Mother, Father, Brother, Sister, Son, Daughter.</p>
		<p>A “Non-Immediate Family Member” would a: Aunt, Uncle, Niece, Nephew, Cousin, Half-brother, and Half-sister.</p>
		<p>An immediate relative is any relative who is one ‘meiosis’ away from a particular individual in a family (e.g., parent, sibling and offspring). <i>Note:</i> A half-brother, half-sister, would be considered as a 2nd degree family member.</p>
		<p>There will be cases in which a patient has both a first degree relative and a second degree relative with a history of cancer. If the patient and a relative share a common primary site, record these fields in regard to</p>

Item No.	Data Item/Field	Value to be Entered
		the relative with the same primary site, regardless of relationship. If the patient and all relatives have tumors involving non-similar primary sites, record these fields in regard to the cancer history of the first degree relative.
		<i>Example 1:</i> Patient is diagnosed with breast cancer. Father has history of colon cancer; maternal aunt has history of breast cancer. <i>Refer to the aunt's cancer history since she shares the same primary site.</i>
		<i>Example 2:</i> Patient is diagnosed with breast cancer. Father has history of colon cancer; a maternal uncle has history of prostate cancer. <i>Refer to the father's cancer history since he is the immediate (first degree) family member.</i>

**Note**

There is no Field Context Help available in Abstract Plus for Family History of Cancer.

**Important**

The user defined codes for Family History of Cancer have been established by the MCSP. To assist with coding MI20 Family History of Cancer the user defined codes and descriptions are provided below.

Code	Description
0	Family hx=no, immediate=no, same site=no
1	Family hx=yes, immediate=yes, same site=yes
2	Family hx=yes, immediate=yes, same site=no
3	Family hx=yes, immediate=no, same site=yes
4	Family hx=yes, immediate=no, same site=no
5	Family hx=yes, immediate=yes, same site=blank
6	Family hx=yes, immediate=blank, same site=yes
7	Family hx=yes, immediate=blank, same site=no
8	Family hx=yes, immediate=blank, same site=blank
9	Family hx=blank, immediate=blank, same site=blank
A	Family hx=yes, immediate=no, same site=blank

If unknown or not reporting, type 9.

Do not leave this data item blank.

17. **MI21 Alcohol History:** Type whether or not the patient has a History of Alcohol Use by using the pull-down list provided and press **Enter**.

Item No.	Data Item/Field	Value to be Entered
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There is no Field Context Help available in Abstract Plus for Alcohol History.



The user defined codes for Alcohol History have been established by the MCSP. To assist with coding the MI21 Alcohol History the user defined codes and descriptions are provided below.

Code	Description
1	Current=checked, prior=blank, never=blank
2	Current=blank, prior=checked, never=blank
3	Current=blank, prior=blank, never=checked
9	Current=blank, prior=blank, never=blank

If unknown or not reporting, type 9.

Do not leave this data item blank.

18. **MI22 Tobacco History:** Type whether or not the patient has a History of Tobacco Use by using the pull-down list provided and press **Enter**.



There is no Field Context Help available in Abstract Plus for Tobacco History.



The user defined codes for Tobacco History have been established by the MCSP. To assist with coding MI22 Tobacco History the user defined codes and descriptions are provided below.

Code	Description
1	Current=checked, prior=blank, never=blank
2	Current=blank, prior=checked, never=blank
3	Current=blank, prior=blank, never=checked
9	Current=blank, prior=blank, never=blank

If unknown or not reporting, type 9.

Do not leave this data item blank.

ENTERING CANCER IDENTIFICATION INFORMATION

Item No.	Data Item/Field	Value to be Entered
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Item No.	Data Item/Field	Value to be Entered
23.	Casefinding Source:	<p>Type the Casefinding Source code and press Enter.</p> <p>This data item codes the type of source through which the tumor was first identified at the reporting facility.</p> <p>Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
30.	Date of Diagnosis:	<p>Type the Date of Diagnosis in the YYYYMMDD format and press Enter.</p> <p>Record the date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed.</p> <p>If the year is unknown, estimate the diagnosis year based upon documentation in the medical record and how long the patient has had the diagnosis.</p> <p>If the month is unknown, use the month of July (7) for the month of diagnosis.</p> <p>If the day is unknown, use the fifteenth (15) for the day of diagnosis.</p> <p>Do not leave any part of this data item blank.</p>
	Date of Diagnosis Flag:	<p>Type the code that explains why there is not a valid value in the corresponding Date of Inpatient Discharge field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this data item blank if there is a valid date value in Date of Inpatient Discharge.</p>
31.	Primary Site:	<p>Type the 4-digit ICD-O-3 topography code for the primary site being reported and press Enter.</p> <p>To view a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. In the</p>

Item No.	Data Item/Field	Value to be Entered
		<p>search box, type the name of the primary site being reported (e.g., if reporting a lung primary type lung). Double click on the appropriate site or highlight and press Enter. You may need to use the scroll bar to display additional values.</p> <p>To launch the SEER Hematopoietic Database (DB), which is used to determine the Primary Site, Histologic Type and Grade for all Hematopoietic and Lymphoid Neoplasm 9590/3-9992/3 (e.g., Leukemia, Lymphoma, Myelodysplastic neoplasms), click the blood drop icon in the Lookup Window, or the blood-drop icon on the menu bar.</p> <p>Do not leave this data item blank.</p>
32.	Laterality:	<p>Type the Laterality code and press Enter. Laterality refers to a specific side of the body or lobe of an organ. In the case of paired or bilateral organs, it is important to indicate whether the primary site of the tumor is the right organ, the left organ, or bilateral involvement.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>If the organ is <u>not</u> a paired site, type 0.</p> <p>Do not leave this data item blank.</p>
37.	Lymph-vascular Invasion:	<p>Type the code to indicate whether lymph vascular invasion (LVI) is identified in the pathology report and press Enter.</p> <p>This field records the absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Use code 0 when the pathology report indicates that there is no lymph-vascular. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.</p>

Item No.	Data Item/Field	Value to be Entered
		<p>For more information, refer to the current CS Manual at http://www.cancerstaging.org/cstage/Pages/default.aspx.</p> <p>Do not leave this data item blank.</p>
33a.	Histologic Type ICD-O-3:	<p>Type the 4-digit ICD-O morphology code for the histologic type of the tumor being reported and press Enter.</p> <p>Use the <i>International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book</i> to assign the histology or morphology code for solid tumors. Example: 8140 = adenocarcinoma, NOS.</p> <p>Use the current <i>Multiple Primary and Histology Coding Rules Manual</i> when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.</p> <p>Use the <i>Hematopoietic and Lymphoid Neoplasm Database and Coding Manual</i> for lymphoma, leukemia and other hematopoietic neoplasms (non-solid tumors). Follow the instructions in the <i>Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual</i>, which has been installed and is run as a separate application on your computer.</p> <p>Or to view a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear.</p> <ul style="list-style-type: none"> • To code the histologic type for hematopoietic and lymphoid neoplasms diagnosed 2010 and later, click on the blood-drop icon to run the Hematopoietic Database. • For all other neoplasms, type the name of the histologic type of tumor being reported (e.g., adenocarcinoma arising in adenomatous polyp) in the search box. Double click on the appropriate histologic type or highlight and

Item No.	Data Item/Field	Value to be Entered
		press Enter . You may need to use the scroll bar to display additional values.
		Do not leave this data item blank.
33b.	Behavior Code ICD-O-3:	Type the Behavior code and press Enter .
		Or double click on the appropriate code in the pull-down list.
		Do not leave this data item blank.
34.	Grade:	Type the code for the grade or degree of differentiation of the primary tumor being reported and press Enter .
		Or double click on the appropriate code in the pull-down list.
		For non-solid tumors , Hematopoietic and Lymphoid Neoplasms (9590-9992) diagnosed January 1, 2010 and forward , refer to the Grade of Tumor Rules in the <i>Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual</i> , which is embedded in the SEER Hematopoietic Database. To open the DB, click on the blood-drop icon on the menu bar.
		Do not use the WHO grade to code this data item.
		Do not leave this data item blank.
35.	Grade Path Value:	Type the value of the grade system used as recorded in the pathology report and press Enter .
		Or double click on the appropriate code in the pull-down list.
		This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system.
		The Grade Path Value supplements but does not replace the field Grade/Differentiation, which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules.

Item No.	Data Item/Field	Value to be Entered
		<p>Grade Path Value is paired with Grade Path System to describe the original grade of the tumor.</p> <p>For more information, refer to the <i>MCSP Cancer Program Manual</i> at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.</p> <p>If not applicable, leave this data item blank.</p>
36.	Grade Path System:	<p>Type the value of the grade system used as recorded in the pathology report and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system.</p> <p>This is the grade system stated in the path report; it is not converted. This item is used in conjunction with Grade Path Value and is abstracted in addition to Grade.</p> <p>The Grade Path Value supplements but does not replace the field Grade/Differentiation, which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules.</p> <p>Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.</p> <p>For more information, refer to the <i>MCSP Cancer Program Manual</i> at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.</p> <p>If not applicable, leave this data item blank.</p>
38.	Diagnostic Confirmation:	<p>Type the Diagnostic Confirmation code and press Enter. (This field records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.)</p>

Item No.	Data Item/Field	Value to be Entered
		Or double click on the appropriate code in the pull-down list.

Do not leave this data item blank.

ENTERING STAGE/PROGNOSTIC FACTORS

Item No.	Data Item/Field	Value to be Entered
39.	SEER Summary Stage 2000:	Type the SEER Summary Stage code and press Enter .

You must use the *SEER Summary Staging Manual - 2000*, codes and coding instructions for **cases diagnosed on or after January 1, 2001**. To download and/or print the manual, go to <http://seer.cancer.gov/tools/ssm/>

Summary stage should include all information available through completion of surgery (ies) in the *first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer*.

Or double click on the appropriate code in the pull-down list.

Summary Stage is a **required** data item **regardless of facility type**.

Do not leave this data item blank.

40.	TNM Clin T:	Type the code that evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known <i>prior</i> to the start of any therapy and press Enter .
-----	--------------------	--

Valid 'Clinical T' codes are as follows:

X	1B	3
0	1B1	3A
A	1B2	3B
IS	1C	3C
ISPU	1D	3D
ISPD	2	4
1M1	2A	4A

Item No.	Data Item/Field	Value to be Entered		
		1MI	2A1	4B
		1	2A2	4C
		1A	2B	4D
		1A1	2C	4E
		1A2	2D	88

Blank is **not** an allowable value for TNM Clinical T in Abstract Plus v3.3.1.2.

If not applicable, no code assigned in current AJCC manual, type 88.

If not recorded, type X.

For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules.

For additional information on general instructions for coding, refer to the *Facility Oncology Registry Data Standards (FORDS)* manual at

Do not leave this data item blank.

40. cont. **TNM Clin N:**

Type the code that identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known **prior** to the start of any therapy and press **Enter**.

Valid 'Clinical N' values are as follows:

Blank*	1B
X	1C
0	2
0I-	2A
0I+	2B
0M-	2C
0M+	3
1MI	3A
0A	3B
0B	3C
1	4
1A	88

***Blank** is **not** an allowable value for TNM Clinical M in Abstract Plus v3.3.1.2.

Item No.	Data Item/Field	Value to be Entered
		<p>If not applicable, no code assigned in current AJCC manual, type 88.</p> <p>If not recorded, type X.</p> <p>For further information, refer to the current <i>AJCC Cancer Staging Manual</i> for staging rules.</p> <p>Do not leave this data item blank.</p>
40. cont.	TNM Clin M:	<p>Type the code that identifies the presence or absence of distant metastasis (M) of the tumor known <i>prior</i> to the start of any therapy and press Enter.</p> <p>Valid 'Clinical M' values are as follows:</p> <p>Blank*</p> <p>X (AJCC editions 1-6 ONLY)</p> <p>0</p> <p>0I+</p> <p>1</p> <p>1A</p> <p>1B</p> <p>1C</p> <p>1D</p> <p>1E</p> <p>88</p> <p>*Blank is <u>not</u> an allowable value for TNM Clinical M in Abstract Plus v3.3.1.2.</p> <p>If not applicable, no code assigned in current AJCC manual, type 88.</p> <p>If CS Mets at DX is recorded as '00 – None,' TNM Clinical M must be recorded as '0 – No distant metastasis.</p> <p>For further information, refer to the current <i>AJCC Cancer Staging Manual</i> for staging rules.</p> <p>Do not leave this data item blank.</p>
40. cont.	TNM Clin Stage Group:	<p>Type the code that identifies the anatomic extent of disease based on the T, N, and M elements known <i>prior</i> to the start of any therapy, and press Enter.</p>

Item No.	Data Item/Field	Value to be Entered
		Valid 'Clinical Stage Group' codes are as follows:
		0 1S 3C1
		0A 2 3C2
		0IS 2A 4
		1 2A1 4A
		1A 2A2 4A1
		1A1 2B 4A2
		1A2 2C 4B
		1B 3 4C
		1B1 3A OC
		1B2 3B 88
		1C 3C 99
		If not applicable, no code assigned in current AJCC manual, type 88.
		If not recorded, type 99.
		Do not leave this data item blank.
40. cont.	TNM Clin Descriptor:	Type the code that identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor <i>prior</i> to the start of any therapy and press Enter . Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.
		Valid 'Clinical Descriptor' codes are as follows:
		0 None
		1 E–Extranodal, lymphomas only
		2 S–Spleen, lymphomas only
		3 M–Multiple primary tumors in a single site
		5 E&S–Extranodal and spleen, lymphomas only
		9 Unknown; not stated in patient record
		Or double click on the appropriate code in the pull-down list.
		If there is no prefix or suffix descriptors that would be used for this case, type 0.
		If unknown, not stated, type 9.
		For further information, refer to the current <i>AJCC</i>

Item No.	Data Item/Field	Value to be Entered																																				
		<i>Cancer Staging Manual</i> for staging rules.																																				
		Do not leave this data item blank.																																				
40.	TNM Path T:	<p>Type the code that evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known <i>following</i> the completion of surgical therapy and press Enter.</p> <p>Valid ‘Pathological T’ codes are as follows:</p> <table><tr><td>Blank*</td><td>1B</td><td>3</td></tr><tr><td>X</td><td>1B1</td><td>3A</td></tr><tr><td>0</td><td>1B2</td><td>3B</td></tr><tr><td>A</td><td>1C</td><td>3C</td></tr><tr><td>IS</td><td>1D</td><td>3D</td></tr><tr><td>ISPU</td><td>2</td><td>4</td></tr><tr><td>ISPD</td><td>2A</td><td>4A</td></tr><tr><td>1MI</td><td>2A1</td><td>4B</td></tr><tr><td>1</td><td>2A2</td><td>4C</td></tr><tr><td>1A</td><td>2B</td><td>4D</td></tr><tr><td>1A1</td><td>2C</td><td>4E</td></tr><tr><td>1A2</td><td>2D</td><td>88</td></tr></table> <p>*Blank is <u>not</u> an allowable value for TNM Pathologic T in Abstract Plus v3.3.1.2.</p> <p>If not applicable, no code assigned in current AJCC manual, type 88.</p> <p>If not recorded, type X.</p> <p>For further information, refer to the current <i>AJCC Cancer Staging Manual</i> for staging rules.</p> <p>Do not leave this data item blank.</p>	Blank*	1B	3	X	1B1	3A	0	1B2	3B	A	1C	3C	IS	1D	3D	ISPU	2	4	ISPD	2A	4A	1MI	2A1	4B	1	2A2	4C	1A	2B	4D	1A1	2C	4E	1A2	2D	88
Blank*	1B	3																																				
X	1B1	3A																																				
0	1B2	3B																																				
A	1C	3C																																				
IS	1D	3D																																				
ISPU	2	4																																				
ISPD	2A	4A																																				
1MI	2A1	4B																																				
1	2A2	4C																																				
1A	2B	4D																																				
1A1	2C	4E																																				
1A2	2D	88																																				
38. cont.	TNM Path N:	<p>Type the code that identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known <i>following</i> the completion of surgical therapy and press Enter.</p> <p>Valid ‘Pathological N’ values are as follows:</p> <table><tr><td>Blank</td><td>1B</td></tr><tr><td>X</td><td>1C</td></tr></table>	Blank	1B	X	1C																																
Blank	1B																																					
X	1C																																					

Item No.	Data Item/Field	Value to be Entered
		0
		2
		0I-
		2A
		0I+
		2B
		0M-
		2C
		0M+
		3
		1MI
		3A
		0A
		3B
		0B
		3C
		1
		4
		1A
		88

***Blank** is **not** an allowable value for TNM
Pathologic N in Abstract Plus v3.3.1.2.

If not applicable, no code assigned in current AJCC
manual, type 88.

If not recorded, type X.

For further information, refer to the current *AJCC
Cancer Staging Manual* for staging rules.

Do not leave this data item blank.

40. cont. **TNM Path M:**

Type the code that identifies the presence or absence
of distant metastasis (M) of the tumor known
following the completion of surgical therapy and
press **Enter**.

Valid 'Pathological M' values are as follows:

Blank*

X (AJCC editions 1-6 ONLY)

0 (AJCC editions 1-6 ONLY)

1

1A

1B

1C

1D

1E

88

***Blank** is **not** an allowable value for TNM
Pathologic M in Abstract Plus v3.3.1.2.

If not applicable, no code assigned in current AJCC

Item No.	Data Item/Field	Value to be Entered
		manual, type 88.
		For further information, refer to the current <i>AJCC Cancer Staging Manual</i> for staging rules.
		Do not leave this data item blank.
40. cont.	TNM Path Stage Group:	Type the code that identifies the anatomic extent of disease based on the T, N, and M elements known <i>following</i> the completion of surgical therapy and press Enter .
		Valid 'Path Stage Group' codes are as follows:
		0 1S 3C1
		0A 2 3C2
		0IS 2A 4
		1 2A1 4A
		1A 2A2 4A1
		1A1 2B 4A2
		1A2 2C 4B
		1B 3 4C
		1B1 3A OC
		1B2 3B 88
		1C 3C 99
		If not applicable, no code assigned in current AJCC manual, type 88.
		If not recorded, type 99.
		For further information, refer to the current <i>AJCC Cancer Staging Manual</i> for staging rules.
		Do not leave this data item blank.
40. cont.	TNM Path Descriptor:	Type the code that identifies the AJCC pathologic stage (prefix/suffix) descriptor known <i>following</i> the completion surgical therapy and press Enter .
		Valid 'Pathological Descriptor' codes are as follows:
		0 None
		1 E–Extranodal, lymphomas only
		2 S–Spleen, lymphomas only
		3 M–Multiple primary tumors in a single site
		5 E&S–Extranodal and spleen, lymphomas only

Item No.	Data Item/Field	Value to be Entered
		<p>9 Unknown; not stated in patient record</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>If there is no prefix or suffix descriptors that would be used for this case, type 0.</p> <p>If unknown, not stated, type 9.</p> <p>For further information, refer to the current <i>AJCC Cancer Staging Manual</i> for staging rules.</p> <p>Do not leave this data item blank.</p>
	TNM Edition Number:	<p>Type the code that indicates the edition of the AJCC Cancer Staging Manual used to stage the case and press Enter.</p> <p>Or click on the appropriate code in the pull-down list and press Enter.</p> <p>This applies to the manually coded AJCC fields and not the Derived AJCC T, N, M and AJCC Stage Group fields.</p> <p>If not staged (cases that have AJCC staging scheme and staging was not done), type 00.</p> <p>If not applicable (cases that do not have an AJCC staging scheme), type 88.</p> <p>If the Edition number is unknown, type 99.</p> <p>Do not leave this data item blank.</p>
41.	CS Tumor Size:	<p>Type the largest dimension or diameter of the primary tumor in millimeters and press Enter.</p> <p>Example: 1.0 x 2.0 x 1.5 cm tumor is recorded as 020</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis</p>



Item No.	Data Item/Field	Value to be Entered
		<p>fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>CS Tumor Size is a required data item regardless of facility type.</p> <p>For LAB122 Display Type, the next required data item is Vital Status.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004.)</p>
42.	CS Extension:	<p>Type the CS Extension code. Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate extension code or highlight and press Enter. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
43.	CS Tumor Size/Ext Eval:	<p>Type the code that identifies how the CS Tumor Size and CS Extension were determined based on the diagnostic methods employed, and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate Eval code or highlight and press Enter. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>


Item No.	Data Item/Field	Value to be Entered
44.	CS Lymph Nodes:	<p>Type the code that identifies the Regional Lymph Nodes involved with cancer at the time of diagnosis either clinically or pathologically and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
45.	CS Lymph Nodes Eval:	<p>Type the code that identifies how the CS Lymph Nodes was determined based on the diagnostic methods employed and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
46.	Regional Nodes Positive:	<p>Type the exact number of Regional Lymph Nodes identified pathologically that contain metastases and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of</p>

Item No.	Data Item/Field	Value to be Entered
		diagnosis is prior to January 1, 2004).
47.	Regional Nodes Examined:	<p>Type the total number of Regional Lymph Nodes removed and examined pathologically, and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Diagnosis of Date fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
48.	CS Mets at DX:	<p>Type the code that identifies distant site(s) and/or distant lymph nodes with metastases at the time of diagnosis, and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Diagnosis of Date fields to be entered first. Double click on the appropriate code or highlight and press Enter. Use the scroll bar to display additional values.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
49.	CS Mets at Dx-Bone:	<p>Type the code that identifies whether bone is an involved metastatic site. This field is a companion to CS Mets at DX field, and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>If CS Mets at DX is coded to 00, this field must be coded as 0.</p> <p>If CS Mets at DX is not coded to 00, this field may still be coded to 0 if bone is not a site of metastasis.</p> <p>Use code 8, when CS Mets at DX is coded as 98 (not</p>

Item No.	Data Item/Field	Value to be Entered
		applicable for this site).
		If unknown if bone metastases; not documented in patient record, type 9.
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
50.	CS Mets at DX-Brain:	<p>Type the code that identifies whether brain is an involved metastatic site. This field is a companion to CS Mets at DX field, and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>If CS Mets at DX is coded to 00, this field must be coded as 0.</p> <p>If CS Mets at DX is not coded to 00, this field may still be coded to 0 if brain is not a site of metastasis.</p> <p>Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site).</p> <p>If unknown if brain metastases; not documented in patient record, type 9.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
51.	CS Mets at DX-Liver:	<p>Type the code that identifies whether liver is an involved metastatic site, and press Enter. This field is a companion to CS Mets at DX field.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>If CS Mets at DX is coded to 00, this field must be coded as 0.</p> <p>If CS Mets at DX is not coded to 00, this field may still be coded to 0 if liver is not a site of metastasis.</p> <p>Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site).</p> <p>If unknown if liver metastases; not documented in</p>

Item No.	Data Item/Field	Value to be Entered
		patient record, type 9.
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
52.	CS Mets at DX-Lung:	<p data-bbox="800 428 1451 533">Type the code that identifies whether lung is an involved metastatic site. This field is a companion to CS Mets at DX field, and press Enter.</p> <p data-bbox="800 575 1451 644">Or double click on the appropriate code in the pull-down list.</p> <p data-bbox="800 686 1451 756">If CS Mets at DX is coded to 00, this field must be coded as 0.</p> <p data-bbox="800 798 1451 867">If CS Mets at DX is not coded to 00, this field may still be coded to 0 if lung is not a site of metastasis.</p> <p data-bbox="800 909 1479 978">Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site).</p> <p data-bbox="800 1020 1438 1089">If unknown if lung metastases; not documented in patient record, type 9.</p> <p data-bbox="800 1131 1468 1201">Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
53.	CS Mets Eval:	<p data-bbox="800 1243 1468 1312">Type the code that identifies how the CS Metastases at Diagnosis was determined, and press Enter.</p> <p data-bbox="800 1354 1468 1633">Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter. Use the scroll bar to display additional values.</p> <p data-bbox="800 1675 1468 1745">Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
54-78.	Site-Specific Factors:	Collaborative Stage (CS) general instructions for Site-Specific Factors (SSFs) are as follows:

Item No.	Data Item/Field	Value to be Entered
 Note	<i>CS General Coding Instructions - SSFs</i>	
	<p>Site-Specific Factor Field Requirements are modeled after the requirements set forth by the American College of Surgeons. Refer to file “CoC and SEER Combined Site Specific Factors List (140K.XLS)” located at http://seer.cancer.gov/tools/ssf/ for a complete listing of the SSF fields.</p> <p>The information recorded in CS Site-Specific Factor fields differs for each anatomic site. See the most current version of the <i>Collaborative Stage Data Collection System</i> (http://www.cancerstaging.org/cstage/index.html), for further information on rules and site-specific codes and coding structures.</p> <p>The Primary Site, Histology, Date of Diagnosis and Behavior codes must be entered first. Once entered, a check on primary site and histology is run to ascertain whether or not SSF25 is required for schema identification.</p> <p>If SSF25 is required for schema identification, a Lookup window will appear. Double click on the appropriate code or highlight and press Enter.</p> <p>If SSF25 is not applicable for the schema based upon the Primary Site and Histology codes entered, the automatic defaulting will delineate what SSFs are not defined for the identified schema, and the running of edits will delineate what SSFs are required.</p> <p>If a SSF default value is 988, the field has been disabled (SSF not applicable for the schema based upon the Primary Site and Histology codes entered). Defined, required SSFs will not be defaulted, and they will be listed as edit errors in the Edit Results window (MCSP Abstract Plus Display Type: Hospital). You will need to enter a valid code for these SSFs.</p> <p>For more information on Michigan specific reporting requirements for CS, refer to the MCSP Cancer Program Manual at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html</p> <p>Do not leave SSF fields blank (unless the date is prior to January 1, 2004.)</p> <p>For LAB130 Display Type (Independent Laboratory), SSFs 2-24 are not Required.</p>	
 Note	Site-Specific Factors:	MCSP cancer reporting requirements for Site-Specific Factor (SSFs) are as follows:
	<i>MCSP Cancer Reporting Requirements - SSFs</i>	
	<p>The Michigan Cancer Surveillance Program (MCSP) has created a color coded spreadsheet that indicates which SSF fields are required. This spreadsheet is named “MCSP SSF Requirements by Primary Site Jan 2013” and can be downloaded from the MCSP website at (http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html).</p>	

Item No.	Data Item/Field	Value to be Entered
	<p>Collaborative Staging v02.04 requires values for ALL SSF fields in abstracts submitted to the MCSP. Those SSF fields highlighted in orange will be REQUIRED (REQ) or REPORTABLE (REP) based upon facility type. For more information on facility types, refer to the “MCSP Reporting Requirements by Item and Facility Type Jan 2013” at (http://www.michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html).</p> <p>If a SSF is defined for the entered schema, it will not be automatically defaulted, as valid values will exist and can be coded for the SSF. However, there will be SSFs that are defined for schemas that are not currently required or collected. Depending on your reporting requirements, these SSFs that are defined but not required <u>may</u> require the entry of 988 (Not applicable, information not collected for this case.)</p> <p>Defined, required SSFs will not be defaulted, and they will be listed as edit errors in the Edit Results window (MCSP Abstract Plus Display Type: Hospital). You will need to enter a valid code for these SSFs.</p> <p>Defined, not required SSFs will not automatically be defaulted and will be counted by the MCSP as edit errors in the Edit Results window. These SSFs will need to be filled in with 988 (Not applicable; information not collected for this case), or 999.</p> <p>As stated earlier in this manual, for Abstract Plus version 3.3, NAACCR v13.0-based software, the APDefault and APDefault2 example display types have CS SSF 1-24 defaulted to the values of 988. This is to save the Abstractor the time of entering 988 for most SSFs for the majority of schemas. The new NAACCR 13.0 metafiles have new edits that will result in an error when the defaulted value of 988 is not valid (i.e., when the Abstractor needs to revise the value of 988 to a valid value for the entered schema). So in order to assess what SSFs are required, all the Abstractor needs to do is run edits once they have entered CS input fields other than the SSFs.</p> <p>For more information on Michigan specific reporting requirements for CS, refer to the MCSP Cancer Program Manual at http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html</p> <p>Do not leave SSF fields blank (unless the date is prior to January 1, 2004.)</p> <p>Submission of data with SSF fields blank (unless date is prior to January 1, 2004) will be rejected by the MCSP.</p>	
	Site-Specific Factors:	MCSP level of reporting requirements for Site Specific Factor (SSFs) are as follows:

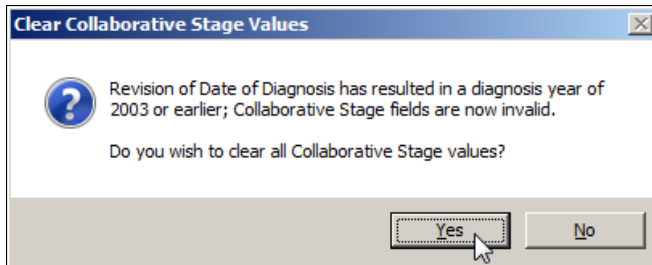
MCSP Level of Reporting Requirements – SSFs

Item No.	Data Item/Field	Value to be Entered
		<p>If a Site Specific Factor field is indicated as REQUIRED (REQ), the facility <u>must</u> collect and report the information with data collection efforts including review of the patient's hospital charts, outpatient record or other available records, but need not make inquiries of other facilities or physician's offices, as it is not the responsibility of the data collector to track down test results if they are not in the patient's medical record(s).</p> <p>If there is no information available, refer to the "MCSP SSF Defaults Jan 2013" at (http://www.michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html) for the correct default code(s), OR to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate default code or highlight and press Enter.</p> <p>Do <u>not</u> leave required Site Specific Factor fields blank (unless the date of diagnosis is prior to January 1, 2004). (Submission of data with required Site Specific Factor fields left blank will be rejected by the MCSP.)</p>

Item No.	Data Item/Field	Value to be Entered
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CS Fields and Tumors Diagnosed 2003 and Earlier

One further helpful feature is that upon entry of a Date of Diagnosis of 2003 and earlier, you will be offered the option of clearing all CS fields.



The Clear Collaborative Staging Values window opens automatically upon entry of a diagnosis year of less than 2004. However, you can clear Collaborative Staging fields at any time by using the **right-click function of Clear Collaborative Stage Fields** or **pressing F9**.



Tip

Undo	Ctrl+Z
Cut	Ctrl+X
Copy	Ctrl+C
Paste	Ctrl+V
Delete	Alt+D
Select All	Alt+A
Field Context Help	F1
Edits Information	F2
Field Message	F3
Run EDITS	F8
Clear Collaborative Stage Fields	F9

54. **CS Site-Specific Factor 1:** Type the CS Site-Specific Factor 1 code needed to generate stage or prognostic/predictive factors and press **Enter**.

Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**.

Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).

Item No.	Data Item/Field	Value to be Entered
55.	CS Site-Specific Factor 2:	<p>Type the CS Site-Specific Factor 2 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
56.	CS Site-Specific Factor 3:	<p>Type the CS Site-Specific Factor 3 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
57.	CS Site-Specific Factor 4:	<p>Type the CS Site-Specific Factor 4 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear.</p> <p>Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>

Item No.	Data Item/Field	Value to be Entered
58.	CS Site-Specific Factor 5:	<p>Type the CS Site-Specific Factor 5 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
59.	CS Site-Specific Factor 6:	<p>Type the CS Site-Specific Factor 6 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
60.	CS Site-Specific Factor 7:	<p>Type the CS Site-Specific Factor 7 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
61.	CS Site-Specific Factor 8:	<p>Type the CS Site-Specific Factor 8 code needed to generate stage or prognostic/predictive factors and</p>

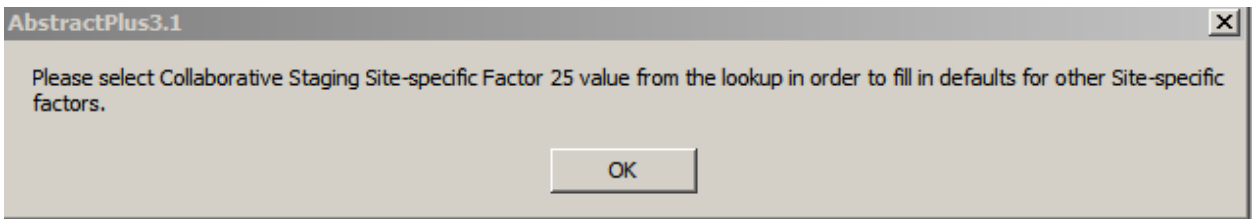
Item No.	Data Item/Field	Value to be Entered
		<p>press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
62.	CS Site-Specific Factor 9:	<p>Type the CS Site-Specific Factor 9 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
63.	CS Site-Specific Factor 10:	<p>Type the CS Site-Specific Factor 10 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
64.	CS Site-Specific Factor 11:	<p>Type the CS Site-Specific Factor 11 code needed to generate stage or prognostic/predictive factors and press Enter.</p>



Item No.	Data Item/Field	Value to be Entered
		<p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
65.	CS Site-Specific Factor 12:	<p>Type the CS Site-Specific Factor 12 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
66.	CS Site-Specific Factor 13:	<p>Type the CS Site-Specific Factor 13 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
67.	CS Site-Specific Factor 14:	<p>Type the CS Site-Specific Factor 14 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or</p>

Item No.	Data Item/Field	Value to be Entered
		<p>press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
68.	CS Site-Specific Factor 15:	<p>Type the CS Site-Specific Factor 15 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
69.	CS Site-Specific Factor 16:	<p>Type the CS Site-Specific Factor 16 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
70.	CS Site-Specific Factor 17:	<p>Type the CS Site-Specific Factor 17 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site,</p>

Item No.	Data Item/Field	Value to be Entered
		Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter .
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
71.	CS Site-Specific Factor 18:	Type the CS Site-Specific Factor 18 code needed to generate stage or prognostic/predictive factors and press Enter .
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter .
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
72.	CS Site-Specific Factor 19:	Type the CS Site-Specific Factor 19 code needed to generate stage or prognostic/predictive factors and press Enter .
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter .
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
73.	CS Site-Specific Factor 20:	Type the CS Site-Specific Factor 20 code needed to generate stage or prognostic/predictive factors and press Enter .
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate

Item No.	Data Item/Field	Value to be Entered
		code or highlight and press Enter .
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
74.	CS Site-Specific Factor 21:	Type the CS Site-Specific Factor 21 code needed to generate stage or prognostic/predictive factors and press Enter .
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter .
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
75.	CS Site-Specific Factor 22:	Type the CS Site-Specific Factor 22 code needed to generate stage or prognostic/predictive factors and press Enter .
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter .
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
76.	CS Site-Specific Factor 23:	Type the CS Site-Specific Factor 23 code needed to generate stage or prognostic/predictive factors and press Enter .
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter .

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
77.	CS Site-Specific Factor 24:	<p>Type the CS Site-Specific Factor 24 code needed to generate stage or prognostic/predictive factors and press Enter.</p> <p>Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the F4 key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press Enter.</p> <p>Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).</p>
78.	CS Site-Specific Factor 25:	<p>Once the Primary Site and Histology codes are entered, a check on primary site and histology is run to ascertain whether or not SSF25 is required for schema identification.</p> <p>If SSF25 is required for the Primary Site and Histology entered, a pop-up box will appear. When you Click on the OK box, a Lookup window automatically opens.</p> <p>Result: A pop-up box appears.</p>  <p>Double click on the appropriate code Site-Specific Factor 25 value or highlight and press Enter.</p> <p>If SSF25 is not required for schema identification, SSF25 will be defaulted to 988 and the field will be disabled.</p> <p>Do not leave this data item blank if SSF25 is required for schema identification (or unless the date of diagnosis is prior to January 1, 2004).</p>

Item No.	Data Item/Field	Value to be Entered
	Derived fields:	General instructions for the Derived Staging fields are as follows:
	 Note	<p>Once all of the Collaborative Stage data elements have been coded, the values are passed through a computer program that generates the correct stage for the case in four systems: <i>AJCC TNM 7th Edition</i>; <i>AJCC TNM 6th Edition</i>; <i>SEER Summary Stage 1977</i>; and <i>SEER Summary Stage 2000</i>.</p> <p>Pressing the F5 key in any derived field will calculate the AJCC Staging and SEER Summary Staging.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Data for each Collaborative Stage (CS) field must be entered before pressing the F5 key to calculate the derived staging fields.</p> <p>Calculation of the Derived fields must be completed if the <u>date of diagnosis</u> is January 1, 2004 forward.</p> <p>AJCC 7th Edition stage is only calculated for cases diagnosed beginning January 1, 2010.</p> <p>Do not leave the Derived Fields blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	 Important	<p>How to compute the Derived Collaborate Stage</p> <p>Once all CS input fields have been filled in, you must derive the CS derived fields as appropriate. Place the cursor in the derived field, and either press F5 or click the calculator icon to the left of the field. In the example shown, all CS derived fields will be calculated or derived.</p> <p>Click the calculator icon to the left of the Derived AJCC-6 T, or press F5.</p>
	Example:	

Item No.	Data Item/Field	Value to be Entered
	CS Site-Specific Factor25	988
	Derived AJCC-6 T	
	Derived AJCC-6 T Descript	
	Derived AJCC-6 N	
	Derived AJCC-6 N Descript	
	Derived AJCC-6 M	
	Derived AJCC-6 M Descript	
	Derived AJCC-6 Stage Grp	
	Derived AJCC-7 T	
	Derived AJCC-7 T Descript	
	Derived AJCC-7 N	
	Derived AJCC-7 N Descript	
	Derived AJCC-7 M	
	Derived AJCC-7 M Descript	
	Derived AJCC-7 Stage Grp	
	Derived SS2000	
	Derived SS2000--Flag	
	CS Version Input Current	020440
	CS Version Input Original	020440
	CS Version Derived	

Result: The **Collaborative Staging Result** window open and displays the calculated values.

Collaborative Staging Result

Collaborative Staging Version 020440

Calculation Preference ☒ Compute AJCC ☐ Compute SEER 1977 ☒ Compute SEER 2000

SEER Summary Stage 1977

SEER Summary Stage 2000 IS

AJCC TNM 6 th ed. cTX cN0 cM0 UNK

AJCC TNM 7 th ed. cTX cN0 cM0 UNK

Message

Close

Item No.	Data Item/Field	Value to be Entered
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1. Click **Close**.

Result: The appropriate **derived CS fields are calculated** and values are automatically filled in. In the example shown, all CS derived fields are calculated and filled. In addition the **CS Version Derived** field is also automatically filled upon derivation.

Derived AJCC-6 T	99
Derived AJCC-6 T Descript	c
Derived AJCC-6 N	00
Derived AJCC-6 N Descript	c
Derived AJCC-6 M	00
Derived AJCC-6 M Descript	c
Derived AJCC-6 Stage Grp	99
Derived AJCC-7 T	999
Derived AJCC-7 T Descript	c
Derived AJCC-7 N	000
Derived AJCC-7 N Descript	c
Derived AJCC-7 M	000
Derived AJCC-7 M Descript	c
Derived AJCC-7 Stage Grp	999
Derived SS2000	0
Derived SS2000-Flag	1
CS Version Input Current	020440
CS Version Input Original	020440
CS Version Derived	020440

2. If an error has been identified, the Collaborative Stage Result window will open and an error message will be displayed.

Result: The **Collaborative Staging Result** window open and an error message will be displayed.



Note

If the primary site and histology initially entered are revised to result in a different schema, you will be offered the option of clearing all CS input fields and re-coding CS for the abstract. Regardless of whether you clear all values and re-code CS, or keep existing values and modify the codes, the above SSF defaulting routine will run again for the newly entered schema.

3. Click **Close**.

Result: The appropriate **derived CS fields are calculated** and values are automatically filled in. In the example shown, all CS derived fields are calculated and filled. In addition the **CS Version Derived** field is also automatically filled upon derivation.

Item No.	Data Item/Field	Value to be Entered
	Derived AJCC-6 T	99
	Derived AJCC-6 T Descript	c
	Derived AJCC-6 N	00
	Derived AJCC-6 N Descript	c
	Derived AJCC-6 M	00
	Derived AJCC-6 M Descript	c
	Derived AJCC-6 Stage Grp	99
	Derived AJCC-7 T	999
	Derived AJCC-7 T Descript	c
	Derived AJCC-7 N	000
	Derived AJCC-7 N Descript	c
	Derived AJCC-7 M	000
	Derived AJCC-7 M Descript	c
	Derived AJCC-7 Stage Grp	999
	Derived SS2000	0
	Derived SS2000--Flag	1
	CS Version Input Current	020440
	CS Version Input Original	020440
	CS Version Derived	020440

- If an error has been identified, the Collaborative Stage Result window will open and an error message will be displayed.

Result: The **Collaborative Staging Result** window open and an error message will be displayed.

Item No.	Data Item/Field	Value to be Entered
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Collaborative Staging Result

Collaborative Staging Version 020440

Calculation Preference ☒ Compute AJCC ☒ Compute SEER 1977 ☒ Compute SEER 2000

SEER Summary Stage 1977

SEER Summary Stage 2000

AJCC TNM 6 th ed. cN0 M0

AJCC TNM 7 th ed.

Message

A failure of AJCC6 TNM, Stage Group, or Eval
 The AJCC6 TNM or Stage Group calculation failed.
 The lookup of T, N, or M for AJCC6 failed.
 T lookup failed.
 AJCC6 Stage Group lookup failed.
 An Eval lookup failed.
 M eval lookup failed.
 A failure of AJCC7 TNM, Stage Group, or Eval
 The AJCC7 TNM or Stage Group calculation failed.
 The lookup of T, N, or M for AJCC7 failed.
 T lookup failed.
 Something in the SEER Summary Stage 77 calculation failed.
 One or more lookups of TNM for SEER 77 failed.
 Extension lookup for SEER 77 failed.
 SEER Summary Stage 77 lookup failed.
 Something in the SEER Summary Stage 2000 calculation failed.
 One or more lookups of TNM for SEER 2000 failed.

Close



If the Collaborative Staging Result window opens and an error message is displayed, the error(s) must be corrected before the derived fields for Collaborative Stage can be calculated.

Derived AJCC-6 T:

Pressing the **F5** key in any derived field will calculate the AJCC-6T field.

Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box.

Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).

Item No.	Data Item/Field	Value to be Entered
	Derived AJCC-6 T Descript:	<p>Pressing the F5 key in any derived field will calculate the AJCC-6T Descript field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-6 N:	<p>Pressing the F5 key in any derived field will calculate the AJCC-6N field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-6 N Descript:	<p>Pressing the F5 key in any derived field will calculate the AJCC-6N Descript field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-6 M:	<p>Pressing the F5 key in any derived field will calculate the AJCC-6M field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-6 M Descript:	<p>Pressing the F5 key in any derived field will calculate the AJCC-6M Descript field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p>

Item No.	Data Item/Field	Value to be Entered
		Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-6 Stage Grp:	Pressing the F5 key in any derived field will calculate the AJCC-6T Stage Group field. Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.
		Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-7 T:	Pressing the F5 key in any derived field will calculate the AJCC-7T field. Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.
		Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-7 T Descript:	Pressing the F5 key in any derived field will calculate the AJCC-7T Descript field. Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.
		Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-7 N:	Pressing the F5 key in any derived field will calculate the AJCC-7N field. Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.
		Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-7 N Descript:	Pressing the F5 key in any derived field will calculate the AJCC-7N Descript field.

Item No.	Data Item/Field	Value to be Entered
		<p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-7 M:	<p>Pressing the F5 key in any derived field will calculate the AJCC-7M field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-7 M Descript:	<p>Pressing the F5 key in any derived field will calculate the AJCC-7M Descript field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-7 Stage Grp:	<p>Pressing the F5 key in any derived field will calculate the AJCC-7 Stage Grp field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived SS2000:	<p>Pressing the F5 key in any derived field will calculate the SS2000 (SEER Summary Stage 2000) field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>

Item No.	Data Item/Field	Value to be Entered
	Derived SS1977:	<p>Pressing the F5 key in any derived field will calculate the SS1977 (SEER Summary Stage 1977) field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived AJCC-Flag:	<p>Pressing the F5 key in any derived field will calculate the AJCC-Flag field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived SS2000 Flag:	<p>Pressing the F5 key in any derived field will calculate the SS2000 Flag field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>
	Derived SS1977 Flag:	<p>Pressing the F5 key in any derived field will calculate the SS1977 Flag field.</p> <p>Or double click on the magnifying glass icon next to the field to compute ALL of the derived staging fields. To exit, click on the close box.</p> <p>Do not leave this field blank (unless the date of diagnosis is prior to January 1, 2004).</p>

14. **Comorbid/Complications 1-10 and Secondary Diagnosis 1-10 data items:**



General Coding Instructions:

Depending on whether the hospital has implemented the use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-form.

Item No.	Data Item/Field	Value to be Entered
	<p>Description: Records the patient's preexisting medical conditions, factors, influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer. All are considered secondary diagnosis.</p> <p>Rational: Preexisting medical conditions, factors, influencing health status and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistic when evaluating patient survival and other outcomes. Complications may be related to quality of care.</p> <p>Instructions for Coding:</p> <ul style="list-style-type: none"> • Use <i>Comorbid/Complications #1-10</i> to record ICD-9-CM codes. • Use <i>Secondary Diagnosis #1-10</i> to record ICD-10-CM codes. • Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available. • Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are reported by the billing department at your facility. • Report the secondary diagnoses for this cancer using the following priority rules: <ul style="list-style-type: none"> <i>Surgically treated patients:</i> <ul style="list-style-type: none"> ○ following the most definitive surgery of the primary site ○ following other non-primary site surgeries <i>Non-Surgically treated patients:</i> <ul style="list-style-type: none"> ○ following the first treatment encounter/episode <i>In case of non-treatment:</i> <ul style="list-style-type: none"> ○ following the last diagnostic/evaluation encounter 	
14a.	Comorbid/Complication 1:	<p>Use Comorbid/Complication 1-10 if reporting ICD-9-CM codes. (Use <i>Secondary Diagnosis 1-10</i> to record ICD-10-CM codes.)</p> <p>During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>Code the secondary diagnoses in the sequence in</p>

Item No.	Data Item/Field	Value to be Entered
		<p>which they appear on the discharge abstract or by the billing department at your facility.</p> <p>Type the first secondary diagnoses as listed on the discharge abstract or by the billing department at your facility, and press Enter.</p> <p>If no ICD-9-CM secondary diagnoses were documented, then record 00000 in <i>Comorbid/Complications 1</i> and leave the remaining <i>Comorbid/Complications 2-10</i> data items blank. In the ICD Revision Comorbid field use code '0' (No comorbidities or complications recorded in patients record).</p> <p>If fewer than 10 ICD-9-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>If this information is unknown, not available, not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 2:	<p>If only two comorbid conditions or complications were documented, type the ICD-9-CM code for the second comorbid condition or complication as it appears on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complications</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complications documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 3:	<p>If only three comorbid conditions or complications were documented, type the ICD-9-CM code for the third comorbid condition or complication as it appears on the discharge abstract or by the billing department at your facility, press Enter and leave</p>

Item No.	Data Item/Field	Value to be Entered
		<p>the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complications documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 4:	<p>If only four comorbid conditions or complications were documented, type the ICD-9-CM code for the fourth diagnoses listed as it appears on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complications documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 5:	<p>If only five comorbid conditions or complications were documented, type the ICD-9-CM code for the fifth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complication documented or not</p>

Item No.	Data Item/Field	Value to be Entered
		reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.
14a. cont.	Comorbid/Complication 6:	<p>If only six comorbid conditions or complications were documented, type the ICD-9-CM code for the sixth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complications documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 7:	<p>If only seven comorbid conditions or complications were documented, type the ICD-9-CM code for the seventh diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complications</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complication documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 8:	<p>If only eight comorbid conditions or complications were documented, type the ICD-9-CM code for the eighth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the</p>

Item No.	Data Item/Field	Value to be Entered
		<i>Comorbid/Complication</i> data items.
		Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190
		If no comorbid/complication documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.
14a. cont.	Comorbid/Complication 9:	<p>If only nine comorbid conditions or complications were documented, type the ICD-9-CM code for the ninth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Comorbid/Complication</i> data items blank.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complication documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14a. cont.	Comorbid/Complication 10:	<p>If ten comorbid conditions and complications were documented, type the ICD-9-CM code for the tenth diagnoses as listed on the discharge abstract or by the billing department at your facility, and press Enter.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the <i>Comorbid/Complication</i> data items.</p> <p>Five digits must be entered in order for the code to pass edits. <i>Example:</i> 401.9 must be entered as 40190</p> <p>If no comorbid/complication documented or not reporting (i.e., implementation of ICD-10-CM codes), leave this data item blank.</p>
14b.	Secondary Diagnosis 1:	Use Secondary Diagnosis 1-10 if reporting ICD-10-CM codes. (Use <i>Comorbid/Complications 1-10</i>)

Item No.	Data Item/Field	Value to be Entered
		to record ICD-9-CM codes).
		During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
		Do not mix ICD-9-CM and ICD-10-CM codes in the <i>Secondary Diagnosis</i> data items.
		Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.
		Omit the decimal points when coding.
		Type the ICD-10-CM code for the first secondary diagnoses as listed on the discharge abstract or by the billing department at your facility, and press Enter .
		If no ICD-10-CM secondary diagnoses were documented, record 0000000 in <i>Secondary Diagnosis 1</i> and leave the remaining <i>Secondary Diagnosis</i> data items blank. In the ICD Revision Comorbid field use code '0' (No comorbidities and complications documented in the patient's record).
		If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining <i>Secondary Diagnosis</i> data items blank.
		If not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.
14b. cont.	Secondary Diagnosis 2:	If only two comorbid conditions or complications were documented, type the ICD-10-CM code for the second diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.
		Do not mix ICD-9-CM and ICD-10-CM codes in the <i>Secondary Diagnosis</i> data items.
		Note that, while the ICD-9-Cm <i>Comorbidities and</i>

Item No.	Data Item/Field	Value to be Entered
		<p><i>Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.</p>
14b.	Secondary Diagnosis 3:	<p>If only three comorbid conditions or complications were documented, type the ICD-10-CM code for the third diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.</p>
14b.	Secondary Diagnosis 4:	<p>If only four comorbid conditions or complications were documented, type the ICD-10-CM code for the fourth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do <u>not</u> mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields,</p>

Item No.	Data Item/Field	Value to be Entered
		leaving blanks beyond those characters.
		Omit the decimal points when coding.
		If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.
14b.	Secondary Diagnosis 5:	<p>If only five comorbid conditions or complications were documented, type the ICD-10-CM code for the fifth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.</p>
14b.	Secondary Diagnosis 6:	<p>If only six comorbid conditions or complications were documented, type the ICD-10-CM code for the sixth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p>

Item No.	Data Item/Field	Value to be Entered
		If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.
14b.	Secondary Diagnosis 7:	<p>If only seven comorbid conditions or complications were documented, type the ICD-10-CM code for the seventh diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.</p>
14b.	Secondary Diagnosis 8:	<p>If only eight comorbid conditions or complications were documented, type the ICD-10-CM code for the eighth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-</p>

Item No.	Data Item/Field	Value to be Entered
		CM codes), leave this data item blank.
14b.	Secondary Diagnosis 9:	<p>If only nine comorbid conditions or complications were documented, type the ICD-10-CM code for the ninth diagnoses as listed on the discharge abstract or by the billing department at your facility, press Enter and leave the remaining <i>Secondary Diagnosis</i> data items blank.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.</p>
14b.	Secondary Diagnosis 10:	<p>If ten comorbid conditions or complications were documented, type the ICD-10-CM code for the tenth diagnoses as listed on the discharge abstract or by the billing department at your facility, and press Enter.</p> <p>Do not mix ICD-9-CM and ICD-10-CM codes in the Secondary Diagnosis data items.</p> <p>Note that, while the ICD-9-Cm <i>Comorbidities and Complications</i> were to be followed by zeroes if they did not fill the field, ONLY the actual ICD-10-CM code is to be entered for <i>Secondary Diagnosis</i> fields, leaving blanks beyond those characters.</p> <p>Omit the decimal points when coding.</p> <p>If no comorbid/complication documented or not reporting ICD-10-CM codes (i.e., reporting ICD-9-CM codes), leave this data item blank.</p>
14. cont.	ICD Revision Comorbid:	Type the ICD Revision Comorbid code and press Enter .

Item No.	Data Item/Field	Value to be Entered
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Or double click on the appropriate code in pull-down list.

Do not leave this data item blank.

ENTERING TREATMENT - 1ST COURSE INFORMATION

Item No.	Data Item/Field	Value to be Entered
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79.	RX Summ-Treatment Sta:	Type the code that summarizes the status for all treatment modalities and press Enter .
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Or double click on the appropriate code in the pull-down list.

Do not leave this data item blank.

80a.	Date of 1st Crs RX-CoC:	Enter the year, month and day YYYYMMDD for the Date of First Course of Treatment and press Enter . Consider all therapies that have been administered. This includes any surgery, radiation therapy, chemotherapy, hormone therapy or immunotherapy (biological response modifier therapy) that has been described as a recommended part of the treatment plan.
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Record the FIRST date that the patient received treatment.

For cases of non-treatment, in which a physician decides not to treat a patient or a patient's family member or guardian declines all treatment, the date of first course of treatment is the date this decision was made.

If unknown or not applicable, leave this data item blank.

80b.	Date 1st Crs RX-CoC Flag:	Type the code that explains why there is not an appropriate value in the corresponding Date of First Course of Treatment CoC field and press Enter .
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Or double click on the appropriate code in the pull-down list.

Item No.	Data Item/Field	Value to be Entered
		Leave this data item blank if there is a valid date in the Date 1 st Crs RX-CoC.
81.	RX Summ-Systemic/Sur Seq:	<p>Type the code that explains the Sequencing of Systemic Therapy and Surgical Procedures given as part of the first course of treatment and press Enter.</p> <p>Or double click on the appropriate code in pull-down list.</p> <p>Do not leave this data item blank.</p>
83a.	RX Date-Surgery:	<p>If Surgery was performed, type the date of the most definitive surgical procedure in the YYYYMMDD format and press Enter.</p> <p>Leave this data item blank if information regarding surgery is unknown (e.g., recommended but unknown if given, or date not known; no information available) or not applicable (e.g., no surgery surgical procedure was performed).</p>
83b.	RX Date-Surgery Flag:	<p>Type the code that explains why there is no appropriate value in the corresponding RX Date Surgery field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-Surgery.</p>
84.	RX Summ-Surg Prim Site:	<p>Type the Site-specific Surgery code for the most definitive surgical procedure. This includes treatment given at all facilities as part of the first course of treatment and press Enter.</p> <p>Or to display a searchable list of possible values, click on the magnifying glass icon next to the field, or press the F4 key and a Look-up window will appear. Use of the Lookup window requires the Primary Site and Histology codes to be entered first. Double click on the appropriate surgical code or highlight and press Enter. You may need to use the scroll bar to display additional values.</p>

Item No.	Data Item/Field	Value to be Entered
Do not leave this data item blank.		
82.	Reason No Surgery:	<p>Type the code for Reason No Surgery and press Enter.</p> <p>Or double click on the appropriate code in pull-down list.</p> <p>Do not leave this data item blank.</p>
85.	RX Summ-Surg Oth Reg:	<p>Record the surgical removal of distant lymph nodes or other tissue (s)/organ(s) beyond the primary site and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Do not leave this data item blank.</p>
86.	RX Summ-Scope Reg Lymph Surg:	<p>Type the code that describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Do not leave this data item blank.</p>
87.	RX Summ-Surg/Rad Seq:	<p>Type the code for the Sequencing of Radiation and Surgery given as part of the first course of treatment and press Enter.</p> <p>Or double click on the appropriate code in pull-down list.</p> <p>Do not leave this data item blank.</p>
88a.	RX Date-Radiation:	<p>If Radiation Therapy was administered, type the date which radiation therapy began at any facility that is part of the first course of treatment in the YYYYMMDD format and press Enter.</p> <p>Leave this data item blank if information for Radiation Therapy is unknown or not applicable (e.g., no radiation therapy is planned or given, or radiation therapy planned, but not yet started and/or</p>

Item No.	Data Item/Field	Value to be Entered
		the start date is not available).
88b.	RX Date-Radiation Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding RX Date Radiation therapy field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-Radiation.</p> <p>Do not leave this data item blank.</p>
	RX Summ-Radiation:	<p>Record the code for the type of radiation therapy performed as part of the first course of therapy and press Enter.</p> <p>Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
90.	Rad-Regional RX Modality:	<p>Record the dominant modality of radiation therapy used to deliver the most clinically significant dose to the primary volume of interest during the first course of treatment and press Enter.</p> <p>Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
89.	Reason No Radiation	<p>Record the Reason that No Regional Radiation therapy was administered to the patient and press Enter.</p> <p>Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
91a.	RX Date-Chemo:	<p>If Chemotherapy was administered, type the date treatment first began at any facility that is part of the</p>

Item No.	Data Item/Field	Value to be Entered
		first course of treatment in the YYYYMMDD format and press Enter .
		Leave this data item blank if information regarding Chemotherapy is unknown or not applicable (e.g., no chemotherapy is planned or given; or chemotherapy planned, but not yet started and/or the start date is not available).
91b.	RX Date-Chemo Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding RX Date Chemotherapy field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-Chemo.</p> <p>Do not leave this data item blank.</p>
92.	RX Summ-Chemo:	<p>Type the code for Chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course of treatment and press Enter.</p> <p>Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
	RX Date-Systemic:	<p>Type the date of initiation of Systemic Therapy that is part of the first course of treatment in the YYYYMMDD format and press Enter.</p> <p>Systemic therapy includes <i>Chemotherapy; Hormone Therapy; Biological Response Modifiers; Bone Marrow Transplants; Stem Cell Harvests; and Surgical and/or Radiation Endocrine Therapy</i>.</p> <p>Leave this data item blank if information for Date Systemic Therapy Started is unknown or not applicable (e.g., no systemic therapy planned or given, or planned but not yet started and/or the start date is not available).</p>

Item No.	Data Item/Field	Value to be Entered
	RX Date-Systemic Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding RX Date Systemic field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-Systemic.</p> <p>Do not leave this data item blank.</p>
94a.	RX Date-Hormone:	<p>If Hormone Therapy was administered, type the date treatment first began at any facility that is part of the first course of treatment in the YYYYMMDD format and press Enter.</p> <p>Leave this data item blank if information regarding Date Hormone Therapy is unknown or not applicable (e.g., no hormone therapy is planned or given; or hormone therapy planned, but not yet started and/or the start date is not available).</p>
94b.	RX Date-Hormone Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding RX Date Hormone therapy field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-Hormone.</p> <p>Do not leave this data item blank.</p>
95.	RX Summ-Hormone:	<p>Type the code for Hormone therapy administered as part of first course of therapy and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Do not leave this data item blank.</p>
93.	RX Summ-Transplnt/End:	<p>Type the code for Transplant/Endocrine procedures administered as part of the first course of treatment at this and all other facilities and press Enter.</p>

Item No.	Data Item/Field	Value to be Entered
		<p>Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
96a.	RX Date-BRM:	<p>Type the date of initiation for Immunotherapy (a.k.a. biological response modifier) at any facility in the YYYYMMDD format.</p> <p>Leave this data item blank if information for Date Biological Response Modifier (Immunotherapy) is unknown or not applicable (e.g., no BRM is planned or given; or BRM planned, but not yet started and/or the start date is not available).</p>
96b.	RX Date-BRM Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding Date BRM field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-BRM.</p> <p>Do not leave this data item blank.</p>
97.	RX Summ-BRM:	<p>If Biological Response Modifier (a.k.a. Immunotherapy) agents were administered, type the code for BRM, which began at any facility that is part of the first course of treatment and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>
98a.	RX Date-Other:	<p>Type the date that Other Treatment began at any facility in the YYYYMMDD format and press Enter. (Other Treatment is that which cannot be defined as surgery, radiation, or systemic therapy.)</p> <p>Leave this data item blank if information for Date Other Treatment is unknown or not applicable (e.g.,</p>

Item No.	Data Item/Field	Value to be Entered
		no Other Therapy is planned or given; or Other Therapy planned, but not yet started and/or the start date is not available.)
98b.	RX Date-Other Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding Date Other Therapy field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in RX Date-Other.</p> <p>Do not leave this data item blank.</p>
99.	RX Summ-Other:	<p>Type the code for Other Treatment administered as part of the first course of treatment at this and all other facilities and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values.</p> <p>Do not leave this data item blank.</p>

ENTERING FOLLOW-UP RECURRENCE/DEATH INFORMATION

Item No.	Data Item/Field	Value to be Entered
107.	Vital Status:	<p>Type the Vital Status code as of the date entered in the Date of Last Contact field and press Enter.</p> <p>If the patient is dead, type 0.</p> <p>If the patient is alive, type 1.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Do not leave this data item blank.</p>
100a.	Date of Last Contact:	<p>Type the date of Last Contact of the patient, or the date of death in the YYYYMMDD format and press Enter.</p>

Item No.	Data Item/Field	Value to be Entered
		If unknown or not applicable, leave this data item blank.
100b.	Date of Last Contact Flag:	<p>Type the code that explains why there is not an appropriate value in the corresponding Date of Last Contact field and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>Leave this field blank if a valid date value is provided in Date of Last Contact.</p> <p>Do not leave this data item blank.</p>
109.	Cause of Death:	<p>Type the official Cause of Death code from the death certificate and press Enter.</p> <p>If patient alive at last contact, type 0000.</p> <p>If death certificate not available, type 7777.</p> <p>If death certificate available but underlying cause of death not coded, type 7797.</p> <p>Or click in the Cause of Death box to open the information window and type the appropriate 4-digit code.</p> <p>Do not leave this data item blank.</p>
109. cont.	ICD Revision Number:	<p>Type the ICD revision code used for Cause of Death and press Enter.</p> <p>Or double click on the appropriate code in the pull-down list.</p> <p>If patient is alive at Date of Last Contact, leave the preset default code 0 and press Enter.</p> <p>Do not leave this data item blank.</p>
110a.	Place of Death - State	<p>Enter the USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient expired. For example, if the state</p>

Item No.	Data Item/Field	Value to be Entered
		in which the patient expired is Michigan, use “MI.”
		If the patient has multiple primaries, the Place of Death – State is the same for each tumor.
		If the information is unknown or unreported in the patient’s record, enter “ZZ” or “Unknown.”
		If the patient is still alive, leave this field BLANK.
		For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, see Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html
110b.	Place of Death - Country	Enter the code for the country where the patient expired. If the country is the United States, enter “USA.”
		If the patient has multiple primaries, the Place of Death – Country is the same for each tumor.
		If the information is unknown or unreported in the patient’s record, enter “ZZU” or “Unknown.”
		If the patient is still alive, leave this field BLANK.
		Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes. The ISO alpha-3 Country Codes can be found at http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx

ENTERING OVER-RIDES/CON/SYSTEM ADMINISTRATION INFORMATION

Some computer edits will identify errors within the abstract. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.



If the computer edits identify an error, supporting text documentation **must** be provided in the Remarks Text Field to support the use of an over-ride code.

Item No.	Data Item/Field	Value to be Entered
	Over-ride:	<p>General instructions for all Over-ride fields are as follows.</p> <p>Leave blank if the program does not generate an error message.</p> <p>Leave blank and correct any errors for the case an item is discovered to be incorrect.</p> <p>If the case has been reviewed and it has been verified that the case has been coded correctly, double click on the appropriate code in the pull-down list.</p> <p>For more information on the edit error, right click in the Over-ride field, highlight Field Context Help and left click or press Enter.</p>
	MI Update Flag:	<p>This field is used to indicate whether this is a new cancer report form or an update of a previously submitted cancer report.</p> <p>Double click on the appropriate code in the pull-down list.</p> <p>If a new reportable primary tumor, highlight new cancer report and press Enter.</p> <p>If the report is an update, highlight '2 – update of a previously submitted cancer report,' press Enter and follow the instructions in the MCSP Cancer Report form on how to submit corrections.</p> <p>Do not leave this data item blank.</p>

ENTERING INFORMATION INTO TEXT FIELDS

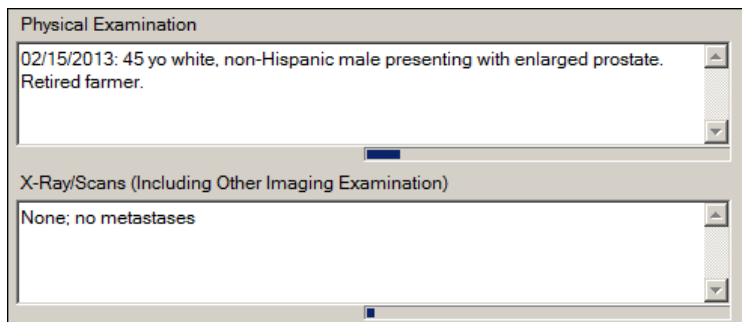
The NAACCR Volume II Data Dictionary defines text documentation as an essential component of a complete electronic abstract. Text information is utilized for quality control and special studies, and is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process and treatments provided should be entered manually from the medical record. It is best practice to

abstract all available text information prior to entering codes for any of the coded cancer identification of treatment data items.

In Abstract Plus, the various text fields are presented within the data entry grid on the right side of the Abstracting Window. The order and names of the text fields that you see are specified by your Abstract Plus Administrator upon set up of the software.

You can scroll up and down in the text entry grid separate from the data entry grid on the left, facilitating the concurrent viewing of text and codes. Note that when entering text, a helpful progress bar is displayed below each text field that indicates how much space is left so that you can properly prioritize the information you are entering.



Text automatically generated from coded data is NOT acceptable.

Text documentation that is continued from one text field to another must be indicated by use of asterisk or other symbol to indicate the connection with previous text field.

Do **not** include irrelevant information.

To undo a text entry error, or to restore accidentally deleted text, immediately right-click and choose “Undo” from the drop-down list.



To access the Registry Plus Online Help for text documentation, right click in text field and scroll down and click on Field Context Help. The Registry Plus Online Help Window will open. The Definition, Rationale, Instructions, Suggestions for text, Data Item(s) to be verified/validated using the text entered are defined by the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary.

Abbreviation listings were developed by abstractors to help abstract necessary information into a limited number of text fields for storage and transmission of cancer data. For a list of the recommended abbreviations for abstractors, refer to Appendix G in the NAACCR Volume II: Data Standards and Data Dictionary at <http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=17>

If there is no information in the text field, DO NOT leave text fields


blank. Type 'N/A', 'Unknown' or 'None' otherwise it will be assumed that the information is actually missing (i.e., the information was documented by the abstractor).



Line returns are not allowed in Abstract Plus text fields. Pressing Enter will move the cursor to the next text field in the text entry grid.

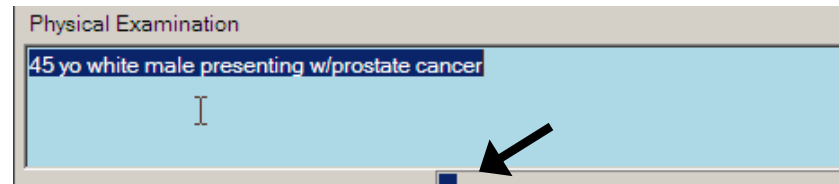
For further information on Entering Information into Text fields, refer to NAACCR Volume II, Data Standards and Data Dictionary at

<http://www.naacccr.org/StandardsandRegistryOperations/VolumeII.aspx>


Item No.	Text Field	Value to be Entered
 Note	Text Fields	<p>General information/instructions for Text Fields are as follows.</p> <p>The text field must contain a description that has been entered by the abstractor independently from the code(s).</p> <p>Information documenting the disease process and treatments provided should be entered manually from the medical record.</p> <p>It is best practice to abstract all available text information prior to entering codes for any of the coded cancer identification of treatment data items.</p> <p>You can scroll up and down in the text entry grid separate from the data entry grid on the left, facilitating the concurrent viewing of text and codes.</p> <p>Note that when entering text, a helpful progress bar is displayed below each text field that indicates how much space is left so that you can properly prioritize the information you are entering.</p>



Tip



Line returns are not allowed in Abstract Plus text fields. Pressing Enter will move the cursor to the next text field in the text entry grid.

Item No.	Text Field	Value to be Entered
	 Important	<p>Text automatically generated from coded data is NOT acceptable.</p> <p>For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with previous.</p> <p>If there is no information to record in the text field, do not leave the field blank. Type 'N/A' or 'unknown' in the appropriate text field to indicate that there is no information available; otherwise it will be assumed that the information is actually missing.</p> <p>If no treatment is performed for a particular data item based upon factors such as primary site, histology, stage, and/or contraindicated due to patient risk factors, record 'none' in the appropriate text field.</p> <p>For more information about treatment, including surgery, chemotherapy, radiation therapy, chemotherapy, immunotherapy or biological response modifier (BRM), go to the National Cancer Institute (NCI) website at: http://www.cancer.gov/cancertopics/types/alphalist.</p> <p>Do not include irrelevant information.</p> <p>Do not leave text fields blank.</p>
101.	Physical Examination (PE):	<p>Text area for the history and physical examination related to the current tumor and the clinical description of the tumor.</p> <p><i>Required for Text:</i></p> <ul style="list-style-type: none"> • Date of physical exam • Age, sex, race/ethnicity • History that relates to cancer diagnosis • Histology (if diagnosis prior to this admission) • Tumor size • Palpable lymph nodes • Record positive and negative clinical findings; record positive results first • Impression (when stated and pertains to cancer)

Item No.	Text Field	Value to be Entered
		<p>diagnosis)</p> <ul style="list-style-type: none"> Treatment plan <p>Example:</p> <ul style="list-style-type: none"> 2012/02/15: 49 yo white, non-Hispanic male presenting w/enlarged prostate. Retired farmer. <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
102.	X-Rays/Scans:	<p>Text area for all X-rays, scan, and/or other imaging examinations that provide information about staging.</p> <p>Required for Text:</p> <ul style="list-style-type: none"> Date(s) of X-ray/Scan(s) Age, sex, race/ethnicity (when given) Primary site Histology (if given) Tumor location Tumor size Lymph nodes Record positive and negative clinical findings. Record positive results first Distant disease or metastasis <p>Key Information:</p> <p>Size and location of primary tumor; relationship of mass to other tissues, such as impingement or extension to another tissue (ribs, chest wall, pleura); elevation of diaphragm on one side (phrenic nerve paralysis); hilar or mediastinal involvement; enlargement or decrease in size of lung(s); opacity, such as atelectasis, pleural effusion or pneumonitis; masses in mediastinum and/or hilum of lung; involvement of distant sites.</p> <p>Examples:</p> <ul style="list-style-type: none"> 2012/02/18: Bone Scan: None, no metastases 2012/07/03: MRI: Involvement of skull base 09/12/2012: Mammogram: 1.5cm lesion

Item No.	Text Field	Value to be Entered
		right upper outer quadrant (UOQ) suspicious for neoplasm
		If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'
		Do not leave this data item blank
103.	Scopes (Endoscopic Exam):	Text area for endoscopic examinations that provide information for staging and treatment.
		<i>Required for Text:</i>
		<ul style="list-style-type: none"> • Date(s) of endoscopic exam(s) • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative clinical findings.
		<i>Example:</i>
		<ul style="list-style-type: none"> • 2012/07/02: Colonoscopy: A 2.5 cm mass located at 25cm. 1.0cm polyp at 15cm. Biopsy recommended.
		If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'
		Do not leave this data item blank.
101.	Lab Tests:	Text area for information from laboratory examinations other than cytology or histopathology.
		Data should verify/validate the coding of the following fields: Date of Diagnosis, Primary Site, Laterality, Histology ICD-O-3, Grade, Collaborative Stage variables, Diagnostic confirmation.
		<i>Note: Not Cytology or Histopathology.</i>
		<i>Required for Text:</i>
		<ul style="list-style-type: none"> • Type of lab test/tissue specimen(s) • Record both positive and negative findings,

Item No.	Text Field	Value to be Entered
		<p>record positive test results first.</p> <ul style="list-style-type: none"> Information can include tumor markers, serum and urine electrophoresis, special studies, etc. Date(s) of lab test(s) Tumor markers included, but are not limited to <ul style="list-style-type: none"> Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her 2/neu. Prostate Cancer: Prostatic Specific Antigen (PSA) Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH) <p>Examples:</p> <ul style="list-style-type: none"> 02/15/2012: PSA elevated 4.6 ng/ml 2012/04/20: ER/PR positive or (+), HER2 negative or (-) <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
84.	OP/Surgical Procedures:	<p>Text area for manual documentation of all surgical procedures that provide information for staging.</p> <p>Data should verify/validate the coding of the following fields: Date of 1st positive Bx; Date of Diagnosis; Rx Summary - diagnostic-staging procedures; Rx Summary -Surgery at primary site.</p> <p>Required for Text:</p> <ul style="list-style-type: none"> Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived. Number of lymph nodes removed Size of tumor removed Documentation of residual tumor Evidence of invasion of surrounding areas <p>Example:</p> <ul style="list-style-type: none"> 02/20/2012: TURP: Incidental finding of adenocarcinoma in situ, 0.1mm. No enlarged lymph nodes.

Item No.	Text Field	Value to be Entered
		<ul style="list-style-type: none"> 2012/01/25: Obstructing lung tumor very close to the main stem bronchus directly extending into the trachea. Enlarged mediastinal lymph nodes. <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
103.	Pathology:	<p>Review the pathology report and type in the text from cytology and histopathology reports.</p> <p><i>Required for Text:</i></p> <ul style="list-style-type: none"> Date(s) of procedure(s) Type of tissue specimen(s) Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.) Gross tumor size; Extent of tumor spread; Involvement of resection margins Number of lymph nodes involved and examined Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored Note if the pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc. Record any additional comments from the pathologist, include differential diagnoses considered, notes, comments, addenda, and any ruled out or favored <p><i>Examples:</i></p> <ul style="list-style-type: none"> 11/12/2012 colon polyp, 1.2x1.0x.0.8 cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia. 2012/07/04 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x .9 cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 01/12/12: lymph nodes negative for cancer; no metastasis noted; Positive histology; ERA negative.

Item No.	Text Field	Value to be Entered
		<p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
31.	Primary Site Title:	<p>Type text information describing the primary site and laterality of the tumor being reported. Be as specific as possible, as many organs can be subdivided into specific segments.</p> <p>Example:</p> <ul style="list-style-type: none"> The pathology report indicates adenocarcinoma of the left upper lobe, lung. <i>Record the primary site as "Lung, left upper lobe," or "Lung, LUL."</i> <p>Do not report the metastatic site as the primary site. If the primary site cannot be determined, type "Unknown Primary Site."</p> <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
33a.	Histology Title:	<p>Review the pathology report and type in the histologic type (adenocarcinoma, squamous cell cancer, etc.), the <i>behavior</i> (malignant, in situ, benign), and the tumor grade (differentiation) of the tumor being reported.</p> <p>Required for text:</p> <ul style="list-style-type: none"> Histologic type and behavior Information on differentiation from scoring system such as Gleason score, Bloom-Richardson for tumor grade; laterality (if paired site) <p>Examples:</p> <ul style="list-style-type: none"> Invasive adenocarcinoma, NOS DCIS, comedo and cribriform type Infiltrating lobular and ductal carcinoma Superficial spreading malignant melanoma Infiltrating squamous cell carcinoma,

Item No.	Text Field	Value to be Entered
		Keratinizing <ul style="list-style-type: none"> • Adenocarcinoma, compatible with non-small cell carcinoma • Nodular sclerosis classical Hodgkin lymphoma, grade not stated • Follicular lymphoma, grade 2, B-cell • Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
103.	Staging:	Additional text area for staging information not already entered in the Test—Dx Proc areas. <p><i>Required for Text:</i></p> <ul style="list-style-type: none"> • Date(s) of procedure(s), including clinical procedures, that provided information for assigning state • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Site(s) of distant metastasis • Physician's specialty and comments • Physician's stage for AJCC <p><i>Examples:</i></p> <ul style="list-style-type: none"> • 2012/02/04: Low anterior resection: Involvement of subcutaneous tissue, regional LNs negative or (-), no bone mets, remainder of exam within normal limits or remainder of exam WNL • 2012/07/05: PE: Physician states nodes are clinically negative. • 2012/03/15: TAH BSO: Extension to adjacent peritoneum, implants on pelvic wall • 2012/05/01: TAH without BSO: FIGO Stage IIC • 2012/06/01: Segmental resection of colon: Regional by direct extension & regional nodes • 2012/12/12: TNM Staging Form: T1, N0, M0

Item No.	Text Field	Value to be Entered
		<p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
84.	Surgery:	<p>Type the text information briefly describing the surgical procedures performed for treatment.</p> <p>Required for text:</p> <ul style="list-style-type: none"> • Date of each procedure • Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Metastatic sites • Facility where each procedure was performed • Record positive and negative findings; record positive findings first <p>Examples:</p> <ul style="list-style-type: none"> • 2012/01/25: Pneumonectomy, NOS, with mediastinal lymph node dissection: Obstructing lung tumor very close to the main stem bronchus directly extending into the trachea. • 04/02/2012: Skin, Right arm: Mos with 1-cm margin • 08/02/2012: Modified radical mastectomy without removal of uninvolved contralateral breast <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
105.	Radiation (Beam):	<p>Type the text information regarding treatment of the tumor being reported with beam radiation.</p> <p>Required for text:</p> <ul style="list-style-type: none"> • Start date when radiation treatment began • Where treatment was given (e.g., at this facility; at another facility)

Item No.	Text Field	Value to be Entered
		<ul style="list-style-type: none"> Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities) Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given) <p>Examples:</p> <ul style="list-style-type: none"> 2012/01/05: 6MV photons at _____ 2012/06/01: Cesium-137, facility unknown 2012/09/01: 4,500 cGY to the head and neck region with 8 MV photons 07/22/2012: Pelvic irradiation to 5,000 cGY, boost to 7,000 cGY <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
105.	Radiation (Other):	<p>Type the text for information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.</p> <p>Required for text:</p> <ul style="list-style-type: none"> Date treatment was started Where treatment was given (e.g., at this facility; at another facility) Type(s) of non-beam radiation (e.g., High Dose rate brachytherapy, seed implant, Radioisotopes [I-131]) Other treatment information (e.g., unknown if radiation was given) <p>Example:</p> <ul style="list-style-type: none"> 2012/06/14: Radioisotopes [I-131] at (include name/location of facility if known) <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>

Item No.	Text Field	Value to be Entered
104.	Chemotherapy:	<p>Type the text for information regarding chemotherapy treatment of the reported tumor.</p> <p><i>Required for text:</i></p> <ul style="list-style-type: none"> • Date when chemotherapy began • Where treatment was given, e.g., at this facility; at another facility • Type of chemotherapy, e.g., name of agent(s) or protocol • Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given <p><i>Examples:</i></p> <ul style="list-style-type: none"> • 2012/07/03: Patient received 6 cycles of CHOP at (include name of facility if known) • 2012/09/15: Per Oncology Report Summary, patient received Adriamycin starting in 09/12 (day not recorded). <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
104.	Hormone Therapy:	<p>Type the text for information about hormonal cancer-directed treatment.</p> <p><i>Required for text:</i></p> <ul style="list-style-type: none"> • Date treatment was started • Where treatment was given, e.g., at this facility; at another facility • Type of hormone or antihormone, e.g., Tamoxifen • Type of endocrine surgery or radiation, e.g., Orchiectomy • Other treatment information, e.g., treatment cycle incomplete, unknown if hormones were given <p><i>Examples:</i></p> <ul style="list-style-type: none"> • 2012/01/15: Per Oncology Treatment Summary Report: Patient started Tamoxifen therapy January 2012, day unknown • Discharge summary: Patient treated with Lupron

Item No.	Text Field	Value to be Entered
		<p>hormonal therapy, starting on 07/12/2012</p> <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
104.	BRM:	<p>Type the text area for information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.</p> <p>Required for text:</p> <ul style="list-style-type: none"> • Date treatment began • Where treatment was given, e.g., at this facility; at another facility • Type of BRM agent e.g., Interferon, BCG • BRM procedures, e.g., bone marrow transplant, stem cell transplant • Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given <p>Example:</p> <ul style="list-style-type: none"> • 2012/05/03: BCG (include name of facility/location if known) <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
104.	Other:	<p>Type the text for information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown) and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.</p> <p>Required for text:</p> <ul style="list-style-type: none"> • Date treatment was started • Where treatment was given (e.g., at this facility; at another facility)

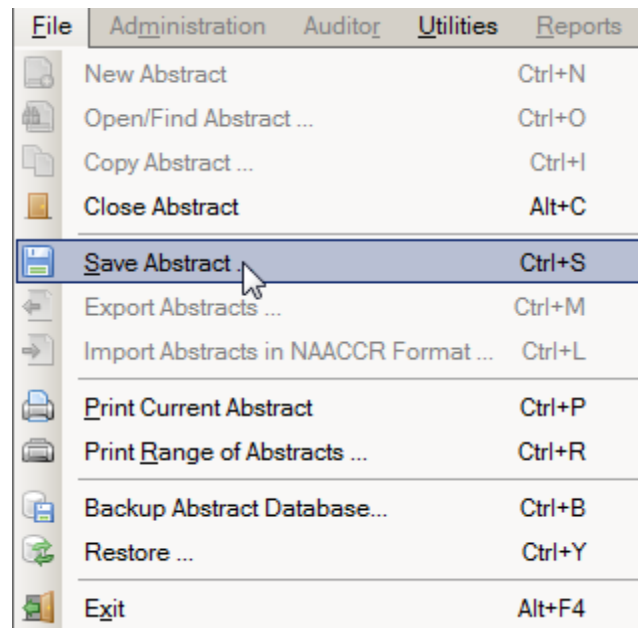
Item No.	Text Field	Value to be Entered
		<ul style="list-style-type: none"> Type of other treatment (e.g., blinded clinical trial, hyperthermia) Other treatment information (e.g., treatment cycle incomplete, unknown if other treatment was given) <p>If not applicable, type 'N/A,' if unknown, record as 'unknown,' if treatment not recommended record as 'none.'</p> <p>Do not leave this data item blank.</p>
105.	Remarks:	<p>Type the text for information that is given only in coded form elsewhere or for which the abstract provides no other place.</p> <p>Type the text for information for Family Medical History, Alcohol History and Tobacco History in Remarks text field.</p> <p>Required for text:</p> <ul style="list-style-type: none"> Overflow data can be placed here Problematic coding issues (e.g., information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown.") Smoking history Family and personal history of cancer (include type and age of onset for each individual if documented) Comorbidities Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date Place of birth Justification of over-ride flags <p>Examples:</p> <ul style="list-style-type: none"> 2012/07/09: PE: Family medical history or FMH: 1 sister w/hx of breast cancer. Social Medical History or SMH: No current or previous history of alcohol or tobacco use. PMH: History of stage T2, N0 M0 breast cancer treated with lumpectomy followed by radiation therapy.


Item No.	Text Field	Value to be Entered
		<ul style="list-style-type: none"> 04/16/2012: Consultation report: FMH/PMH negative, SMH: cigarettes, 1ppd x 40 years, quit 5 years ago <p><i>Do not leave this data item blank. (If not applicable, type N/A)</i></p>
	Place of Diagnosis:	<p>Type the text for the facility, physician office, city, state, or county where the diagnosis was made.</p> <p><i>Required for text:</i></p> <ul style="list-style-type: none"> The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate. For out-of-state residents and facilities, include the city and the state where the medical facility is located <p>If unknown, type Unknown.</p> <p>If not applicable, type N/A.</p> <p><i>Do not leave this data item blank.</i></p>
	Local Text:	<p>Do <u>not</u> use the Local Text field. (This is a State central cancer registry defined user field.)</p> <p>Leave this data item blank.</p>

Saving Abstracts

Once you have entered information into an abstract, it is a good idea to save your work often. To save your work, complete these steps:

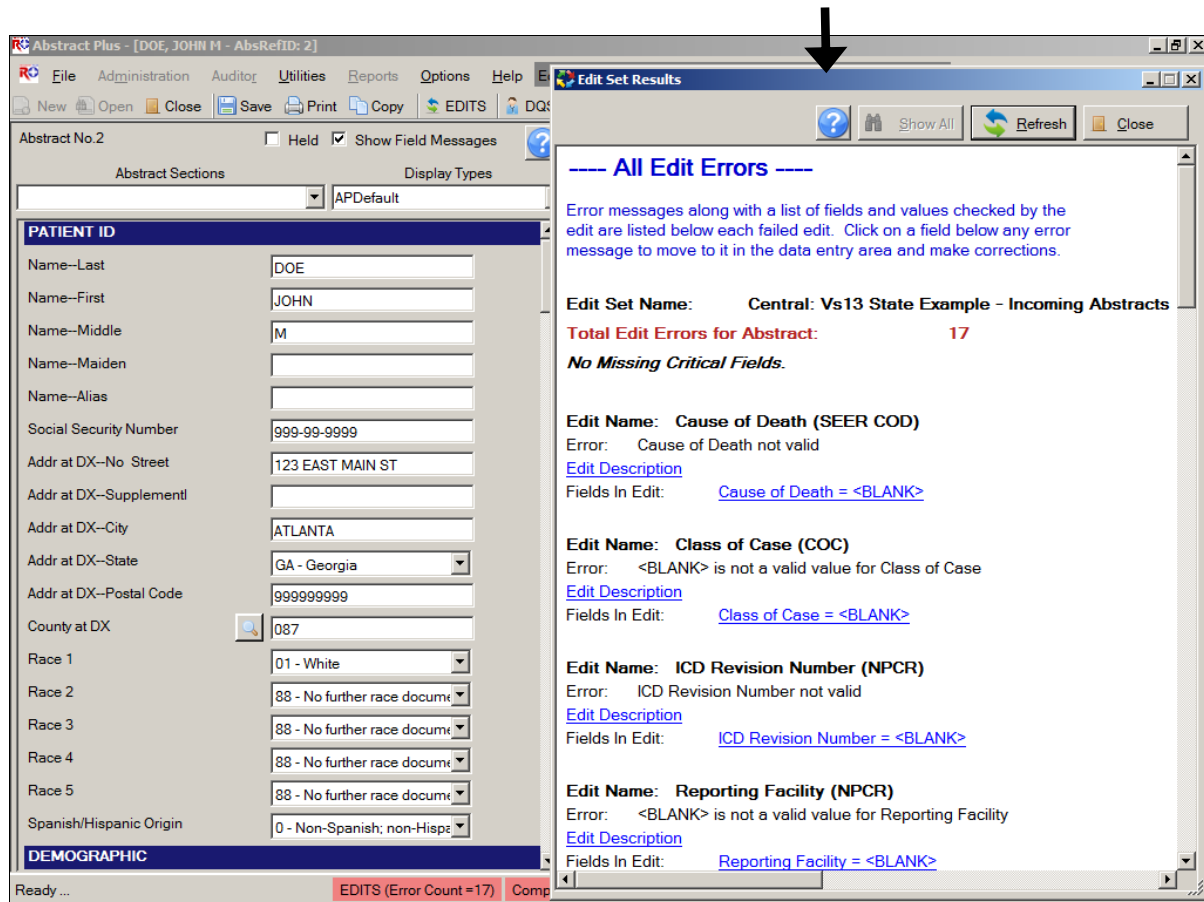
1. Saving an abstract can be done in 3 ways:
 - a. Click on the **File** menu, and select **Save Abstract**.



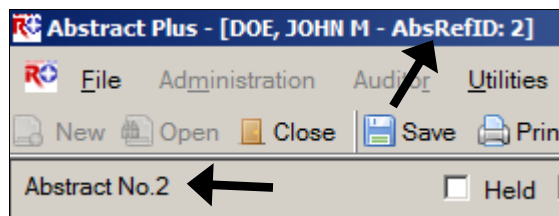
- b. Click the Save icon on the tool bar  Save.
- c. Use the keystroke **Ctrl+S**.

Results:

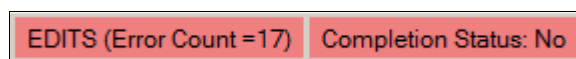
- 1) The **information entered thus far for the abstract is saved** to the database *and*
- 2) **'Edits' will run** (depending on the way your Abstract Plus Administrator set up your Abstract Plus application).
- 3) The **Edit Set Results window** opens and displays information about any edit errors the abstract may contain.



4) Once saved, each abstract is assigned an unique **Abstract Reference ID** (or AbsRefID), displayed in the upper left-hand corner of the data entry area of abstracting window, as well as in the title bar of the application along with the patient name:



5) The EDITS Error Count and Abstract Completion status indicators reflect the current edit error count and completion status of the abstract. If there are any errors within the abstract, both of these indicators will display in red. In the example shown, the abstract contains 17 edit errors and as a result, is deemed incomplete.



Correcting Edit Errors

For any abstract you can run edits and view edit errors by **saving** the abstract, clicking the **EDITS** button on the toolbar, or pressing **F8**.

Each time an abstract is opened or saved Abstract Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.

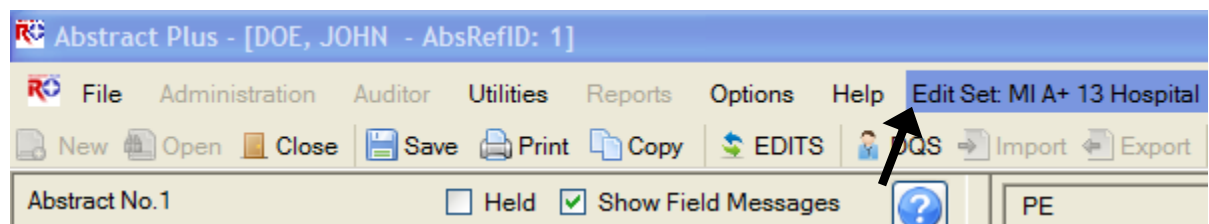


You must resolve all edit errors and fill in all critical (required) fields in order to **complete** the abstract.

Abstract Plus has edit error display features that greatly facilitate the error resolution process. Editing features include:

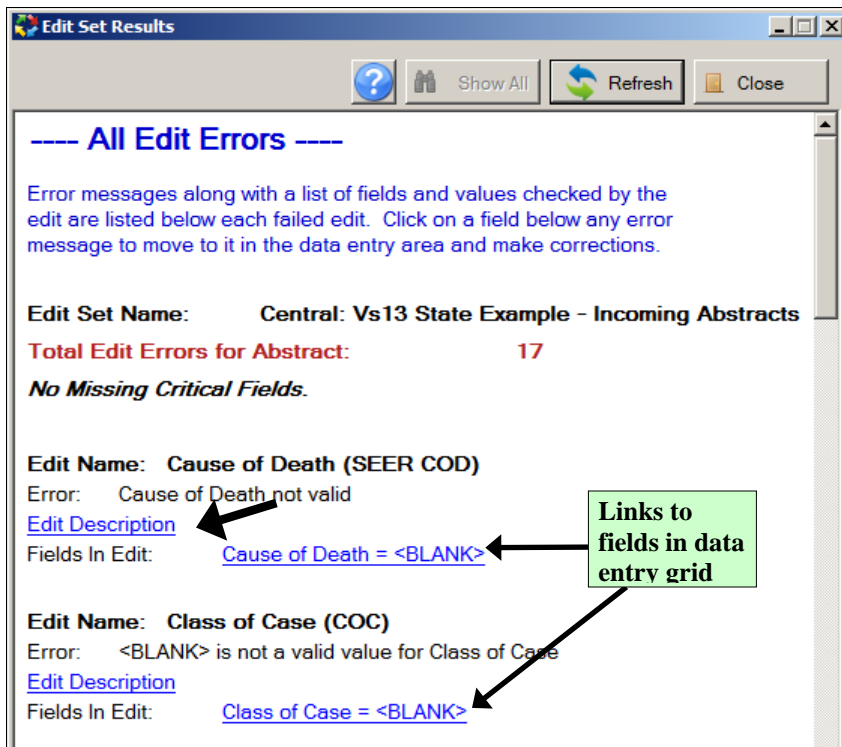
- a. The **edit set** being run on the abstract is clearly **displayed** at the top of the abstracting window. In the **example** shown, the edit set being applied is named **MI A+ 13 Hospital**:

Result: The **edit set** being applied is displayed at the top of the abstracting window.

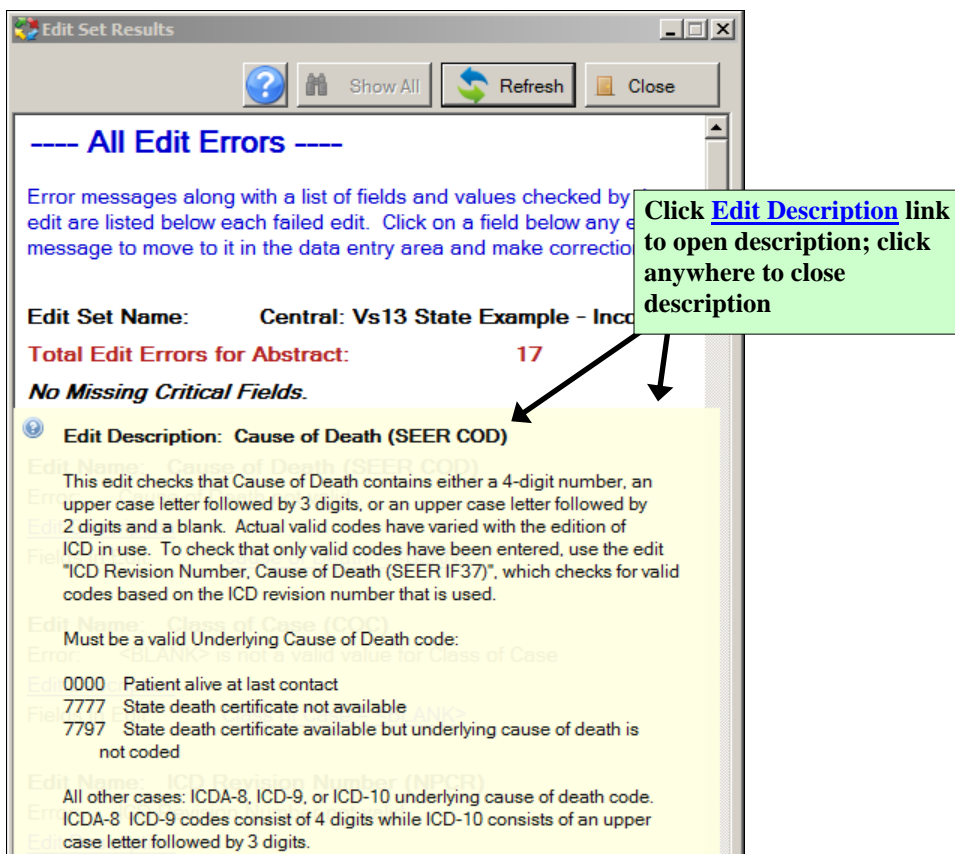



- b. When edits are run, the **Edit Set Results** window automatically opens and displays the full information for any edit errors that exist, or lets you know that there are no errors. The Edit Set Results window lists the total number of edit errors for the abstract, missing critical (required) fields, and the edit errors. For each edit error, the failed edit name, error message, and fields involved in the edit are listed. Using the information listed in the Edit Set Results window to help you resolve the edit errors, you can click on a link to a field to move to it in the data entry grid and make corrections:

Results: The **edit set results** window displays the total number of edit errors for the abstract. See example shown below: Central: Vs13 State Example – Incoming Abstracts – **Total Edit Errors for Abstract: 17**.

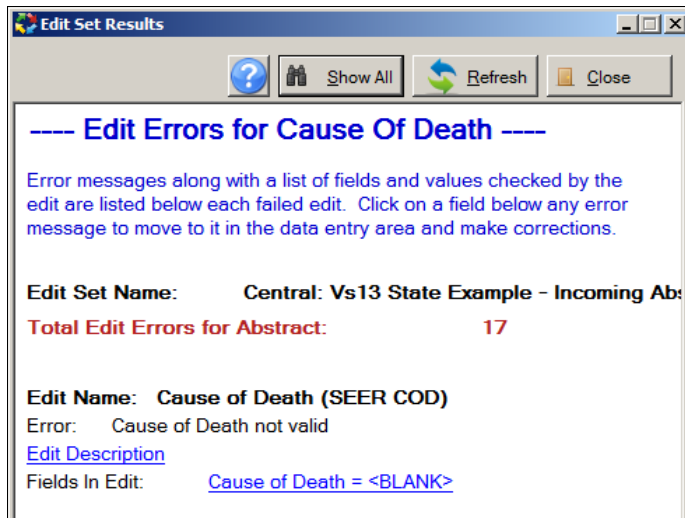


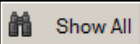
When greater detail regarding the edit is required to resolve the edit error, click on the **Edit Description** link, which expands to display the edit description; once opened, you can click anywhere to close the edit description:



- c. Edit errors can be viewed for the entire abstract, or just for individual fields. You can view **all edit errors** for the abstract as shown above by clicking on the EDITS icon on the toolbar , right-clicking and selecting **Run Edits**, or by pressing **F8**.


Or you can choose to view **edit errors by individual data field** by right-clicking and selecting **Edits Information**, or by pressing **F2**. In the example shown, the edit errors for the individual field of Cause of Death are being viewed:



When viewing edit errors for an individual field, you can **switch** from the individual data field edit errors view to the all edit errors view by clicking on the **Show All**  button.



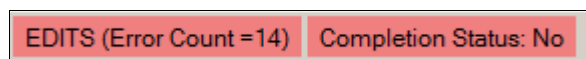
Tip

You can make corrections to fields by clicking on the links to the fields in the Edit Set Results windows. To see your corrections reflected, click the **Refresh**  button.

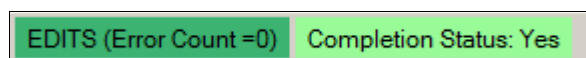
Completing Abstracts

As mentioned, you must resolve all edit errors and fill in all critical (required) fields in order to complete an abstract. Abstract Plus displays helpful, color-coded edits error count and abstract completion status information at the bottom of the abstracting window. Once you have resolved all edit errors and completed all missing critical fields, upon the next save of the abstract, the status information changes from red to green upon completion of the abstract:

Incomplete abstract containing edit errors:



Complete abstract containing no edit errors:

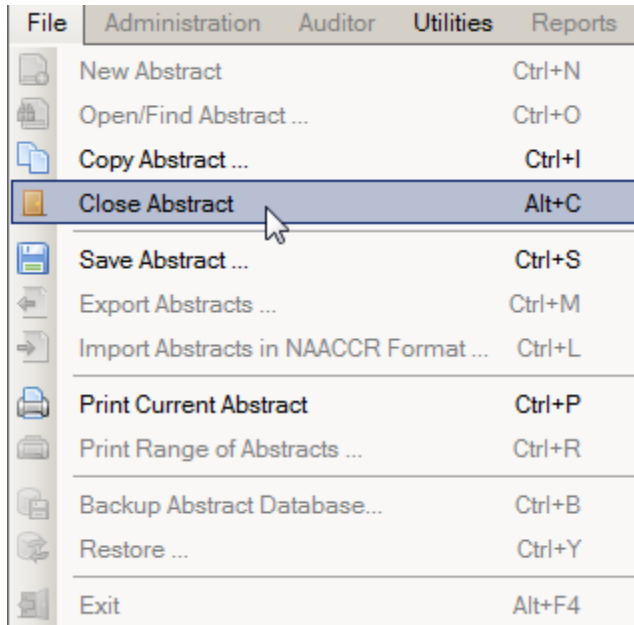


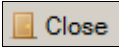
Closing Abstracts

Once you have entered information into an abstract and saved your work, you can close the abstract and open it in the future to complete your work. You can also search for an open completed abstracts.

To close an abstract, complete these steps:

1. Abstracts can be closed in 3 ways:
 - a. Click on the **File** menu, and select **Close Abstract**.



- b. Click the Save icon on the tool bar .
- c. Use the keystroke **Alt+C**.

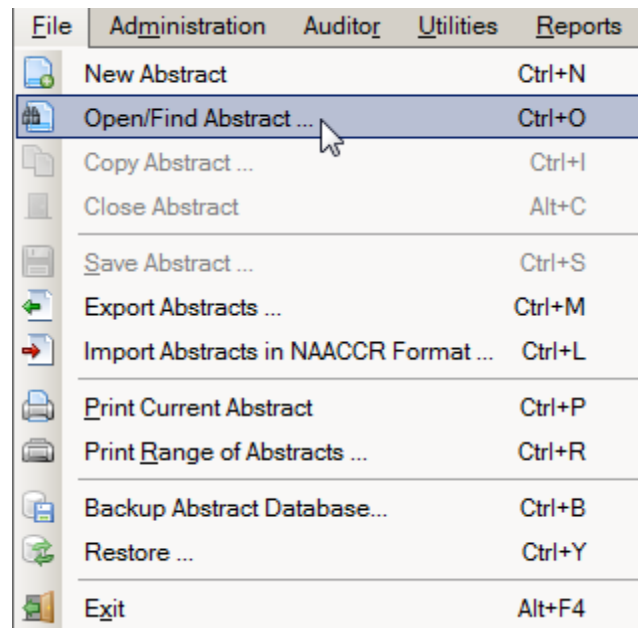
Result: The abstract is closed, and you are returned to the Abstract Plus main window.

Searching for and Opening an Existing Abstract

We have just learned that you can begin abstracting work by creating a new abstract. Another way that you can begin abstracting work is to search for and open an existing abstract.

To find and open an existing abstract, complete these steps:

1. Existing abstracts can be searched for and opened in 3 ways:
 - a. Click on the **File** menu, and select **Open/Find Abstract**.



- b. Click the **Open** icon on the tool bar .
- c. Use the keystroke **Ctrl+O**.

Result: The **Open/Find Abstract** window opens.

Open / Find Abstract

Query Items [Multiple item selection allowed]

☒ All ☐ Complete Abstracts Only ☐ Incomplete Abstracts Only

Item Value

Last Name	First Name	Medical Record #	Social Security #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Note: Partial name search allowed</i>		<i>Example: 12345678901</i>	<i>Example: 123-12-1234</i>

Abstract ID To:

Example: 1234567890 *Example: 12345678901* *Example: 2008/12/15 (YYYY/MM/DD)*

Reporting Hospital

Example: 12345678901

Date of Birth

Example: 2008/12/15 (YYYY/MM/DD)

Query Results:

No Records Found

Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp

The Open/Find Abstract window has two main sections. The **patient query area** is located in the upper portion of window, and the lower portion of the window displays the query results as a list of abstracts from which the abstract of interest can be opened. Abstracts listed can be queried by any combination of patient first and last names, medical record number, social security number, date of birth, reporting hospital, or

Abstract Reference ID. In addition, abstracts can be queried for by abstract completion status by clicking on the appropriate search option at the top of the window.



Tip

If you click the Incomplete Abstracts Only search criteria option, only abstracts for which abstraction has not yet been completed will be displayed; this is very helpful for identifying abstracts yet to be completed.

The abstract list window includes these fields and column headings:

Columns	Description
Name	Name of Patient (Last, First)
Abstract ID	A system-generated number identifying the abstract
Date of Birth	Patient's date of birth
Social Security #	Patient's social security number
Sex	Patient's sex
Acc Num Hosp	Hospital accession number reported by the audited facility for the reported tumor
Seq Num Hosp	Sequence number hospital reported by the audited facility for the reported tumor
Date 1 st Contact	Date of 1 st contact reported by the audited facility for the reported tumor
Diagnosis Date	Diagnosis date of the reported tumor
Primary Site	ICD-O-3 topography code describing the location of the reported tumor
Reporting Hospital	COC code for the reporting facility that reported the tumor
Laterality	Code for the side of a paired organ, or the side of the body on which the reported tumor originated
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the reported tumor
Medical Record #	Patient's medical record number
Date Last Contact	Date last contact reported by the audited facility for the reported tumor
Vital Status	Patient's vital status
Abstract Status	The status of the reabstract---incomplete, complete, or held



Tip

The order of the columns on the abstract list window may be modified. Simply left-click and hold on the column header, and slide the column to the desired position in the column viewing order.

- Query for a patient on the list of tumors to be opened. Enter the **first letter** of the patient's **last name** in the **Last Name search criteria** box on the Open/Find Abstract window, and click **Query**. You can also use any of the other available search criteria to search upon. In the example shown, the abstract being searched for is for a patient named John Doe, so a **D** is entered in the Last Name search criteria box.

The screenshot shows the 'Open / Find Abstract' window. The 'Query Items' section has three radio buttons: 'All' (selected), 'Complete Abstracts Only', and 'Incomplete Abstracts Only'. The 'Item Value' section contains several input fields: 'Last Name' (with 'D' entered), 'First Name', 'Medical Record #' (with example '12345678901'), 'Social Security #' (with example '123-12-1234'), 'Abstract ID' (with example '1234567890'), 'Reporting Hospital' (with example '12345678901'), and 'Date of Birth' (with example '2008/12/15'). A 'Query' button is highlighted. Below the input fields, a table header is visible with columns: Name, Abstract ID, Date of Birth, Social Security #, Sex, Acc Num Hosp, and Seq Num Hosp. The 'Query Results' section at the bottom right displays 'No Records Found'.

Result: The Open/Find Abstract window presents the results of the query, and displays any **potential matches** in the tumor list window.

The screenshot shows the 'Open / Find Abstract' window with the same search criteria as the previous image. The 'Query Results' section now displays '6 Abstracts found.' Below the input fields, a table is shown with the following data:

Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp
DANCER, CANDY	4	19200419	111-11-5015	Female	200100506	01
DAYS, HAPPY	12	19351022	111-11-5016	Female	200101067	02
DAYS, HAPPY	11	19351022	111-11-5016	Female	200101067	01
DOE, JOHN	18	19610316	999-99-9999	Male		00
DRIVER, CABBY	14	19330318	111-11-1078	Male	200101078	04
DRIVER, CABBY	13	19330318	111-11-1078	Male	200101078	03

- From the abstracts listed, locate the abstract of interest and **open it**, either by **double-clicking** the row for the abstract or select the row for the abstract and click **Select**.

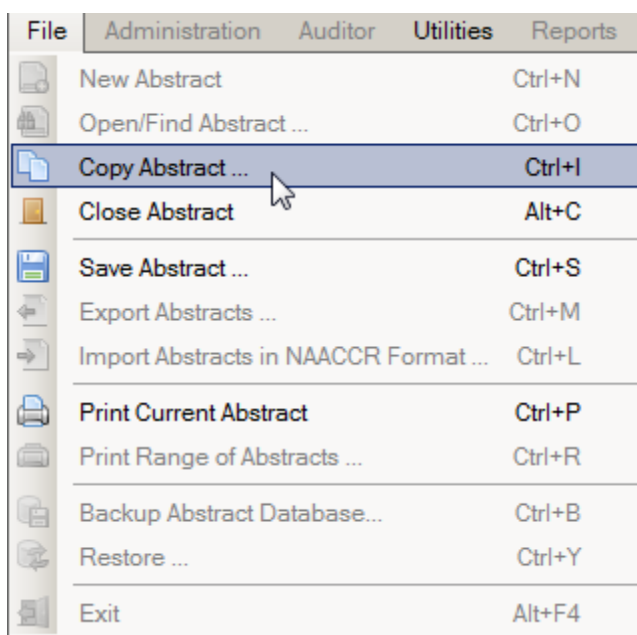
Result: The **Abstract Plus Abstracting** window opens so that you can modify the abstract that has just been opened.

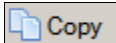
Copying an Abstract

Thus far we have learned that you can begin abstracting work by creating a new abstract, or searching for and opening an existing abstract. The third way to begin abstracting is to copy an existing abstract and modify the information it contains. The copy feature is especially helpful for the reporting of patients with multiple primaries. Simply open the abstract for the first primary for the patient, copy the abstract, and then enter the tumor and treatment information for the subsequent primary tumor.

To copy an abstract, complete these steps:

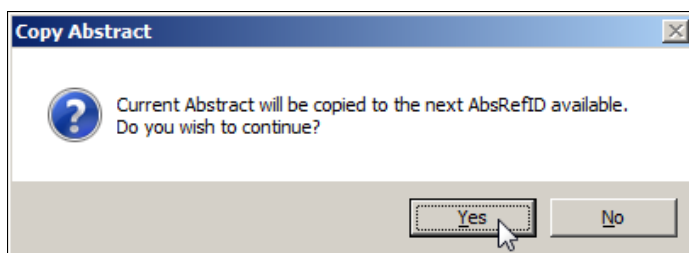
1. Make sure that you have the abstract to be copied open in the abstracting window.
2. Abstracts can be copied in 3 ways:
 - a. Click on the **File** menu, and select **Copy Abstract**.



- b. Click the **Copy** icon on the tool bar .

- c. Use the keystroke **Ctrl+I**.

Result: The **Copy Abstract** dialog window opens and asks you to confirm that you would like to copy the abstract.



3. Click **Yes**.

Result: The abstract is copied to a new Abstract Reference ID. Note that the patient demographics from the original abstract are copied into the new abstract, so that you need only enter information regarding the tumor being abstracted. Edits are run, and the Edits

Error Count and Completion Status indicators will indicate that there are errors (missing fields) for the abstract and that the abstract is incomplete.

The screenshot shows the Abstract Plus software interface. The main window, titled 'Abstract No.3', displays patient information for 'DOE, JOHN M'. The 'DEMOGRAPHIC' section is highlighted. The status bar at the bottom indicates 'EDITS (Error Count =24)' and 'Completion Status'. A secondary window, 'Edit Set Results', is open, showing a list of 'All Edit Errors' with a total of 24 errors. The errors include missing critical fields and invalid values for various edit sets.

Edit Set Name	Error	Fields In Edit
Central: Vs13 State Example - Incoming	Age at Diagnosis (SEER AGEDX)	Age at Diagnosis = <BLANK>
Behavior ICDO3 Conversion (NAACCR)	<BLANK> is not a valid value for Behavior Code ICD-O-3	Behavior Code ICD-O-3 = <BLANK>
Cause of Death (SEER COD)	Cause of Death not valid	Cause of Death = <BLANK>
Class of Case (COC)		

- Once you have finished work on the newly copied abstract, **save** your work, and **close** the abstract.

If you find an abstract that looks very much like an abstract you want to create for the same patient but with a different primary site, you can simply save the abstract as a new one and then modify the necessary fields in the new abstract.

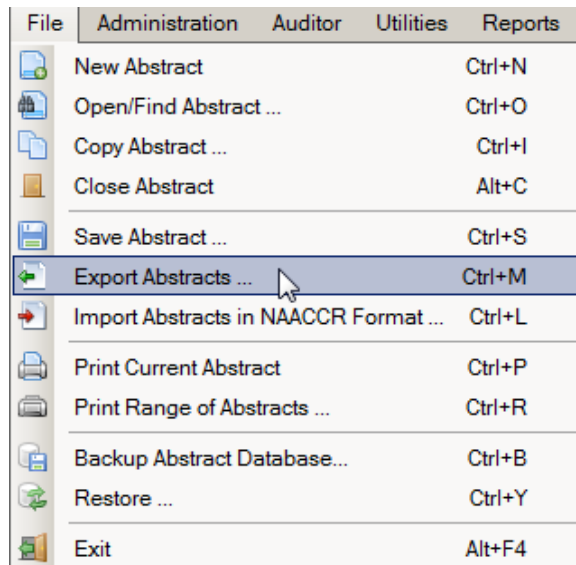
Exporting Abstracts

When exporting abstracts, you can choose to export all abstracts in the abstracts database, including complete and incomplete abstracts, or enter criteria for selecting completed abstracts for export. Depending on how your Abstract Plus Administrator set up your application, the feature for including complete or incomplete abstracts during export may or may not be available to you.

You can export abstracts in NAACCR Layout or Delimited format, depending on options selected by your Abstract Plus Administrator upon setup of the program. The default is to export abstracts in the NAACCR file format. However, when enabled, the delimited format allows you to select which fields and in what order you would like exported in a comma-delimited text file.

To export abstracts, complete these steps:

1. Abstracts can be exported in 3 ways:
 - a. Click on the **File** menu, and select **Export Abstracts**.



- b. Click the **Export** icon on the tool bar  **Export**.
 - c. Use the keystroke **Ctrl+M**.

Result: The **Export Abstracts** window opens, and presents you with different options for exporting abstracts.

You can modify the default options selected on the export window to export only the particular abstracts that you would like to export.



Note

The **Mark Exported Abstracts as Exported** and **Export Only Un-Exported Abstracts To Date** options are selected by default and generally should not be changed as these options will prevent re-export of previously exported abstracts, thus preventing reporting of duplicate abstracts to your central registry.

The Export Abstracts window includes the following options for exporting abstracts:

Export Option	Description
Export All Abstracts in Database	When checked, this option will over-ride any other export option, and all abstracts in the database will be exported regardless of completion status
Mark Exported Abstracts as Exported	When this option is checked, all exported abstracts will be marked as exported; when used in combination with the Export Only Un-Exported Abstracts To Date export option, this prevents duplicate export of abstracts

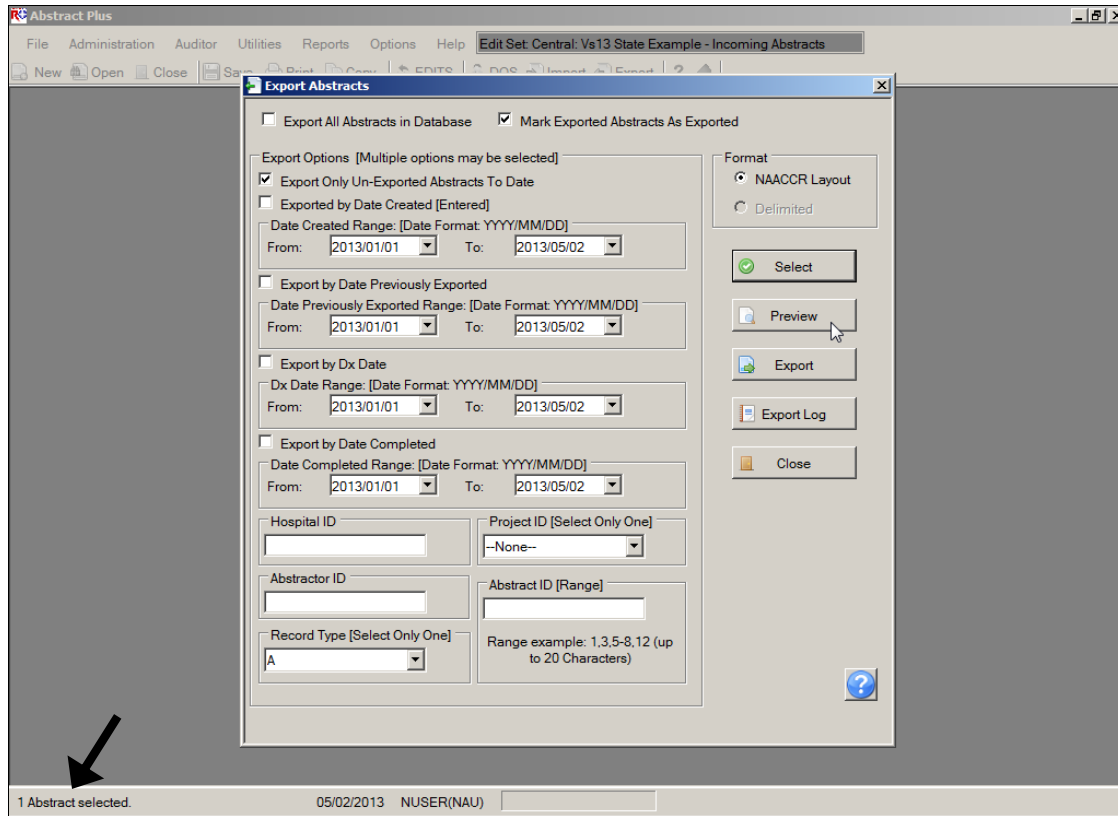
Export Option	Description
Export Only Un-Exported Abstracts To Date	When this option is checked, only those completed abstracts that have not yet been exported will be exported; when used in combination with Mark Exported Abstracts as Exported export option, this prevents duplicate export of abstracts
Export by Date Created	This option allows the user to enter a date range to export completed abstracts by the date they were created
Export by Date Previously Exported	This option allows the user to enter a date range to export previously exported, completed abstracts by the date they were previously exported
Export by Dx Date	This option allows the user to enter a date range to export completed abstracts by the diagnosis date of the tumors reported in the abstracts
Export by Date Completed	This option allows the user to enter a date range to export completed abstracts by the date they were completed
Hospital ID	This option allows the user to enter a facility ID number to export completed abstracts for a particular facility
Project ID	For those users with applications set up to collect information on Projects, this option allows the user to enter a Project ID to export completed abstracts for a particular Project
Abstractor ID	This option allows the user to enter an Abstractor ID to export completed abstracts for a particular Abstractor
Abstract ID	This option allows the user to enter an Abstract Reference ID number (or range of AbsRefIDs) to export specific completed abstracts
Record Type	This option allows the user to enter the Record Type of A or M to export completed abstracts of either of those Record Types



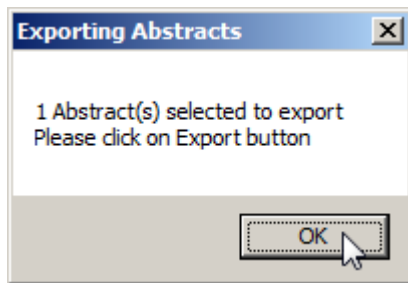
The Export All Abstracts in Database function may only be available to administrators.

2. Select the export options you require, and Click **Select**.

Result: The system displays the number of abstracts that meet the export criteria and are to be exported in the lower left-hand corner of the main window.

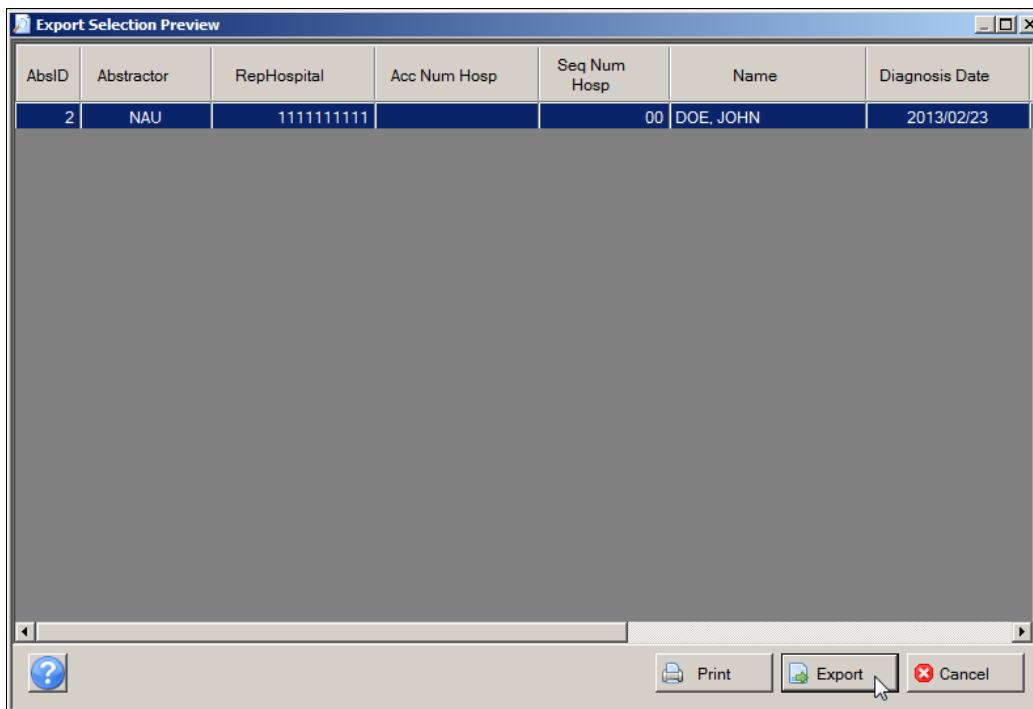


The system also issues a message:



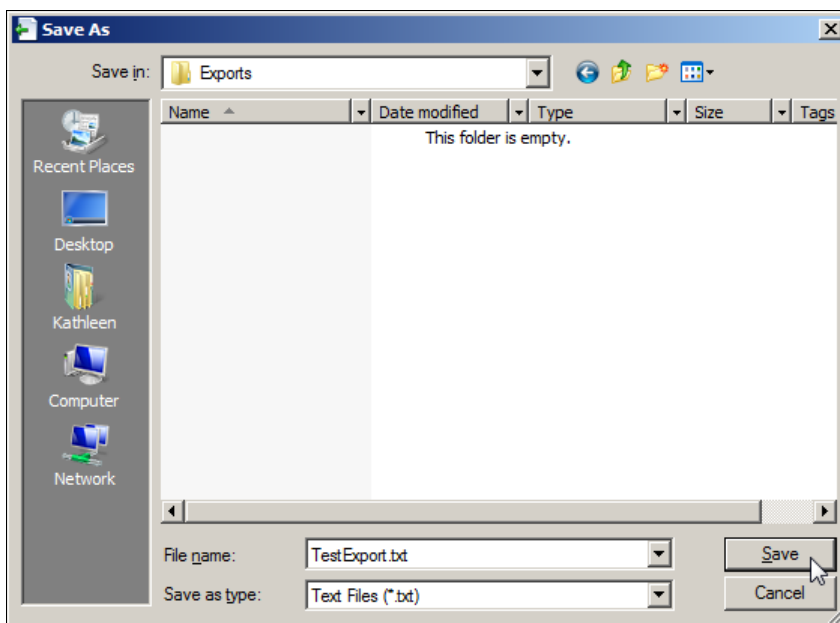
3. Click **OK**.
4. Now click **Preview**.

Result: The Export Selection Preview window opens.



- Click **Export**.

Result: The **Save As** window opens.



- Enter a **file name** for the export file in the File name box and click **Save**. The file name must begin with **MI** followed by the **5-digit Michigan assigned facility number** that is part of your Userid. Next **add the date stamp (YYYYMMDD)**. For example, facility 12345 submitting on a file on April 1, 2014 will have the file name of **MI1234520140401**, along with whatever extension you might wish to add.

Result: The system saves the abstracts into a text file and lets you preview a report that you can print. By Default, Abstract Plus saves your export files to **C:\RegPlus\AbstractPlus\Exports.**



If you are sending more than one file at a time, please make sure that EACH file has a different extension added i.e.: -1, -2, -3, etc. on the file name. For example, the same facility could have the files MI1234520140401-1of3.txt, and so on.

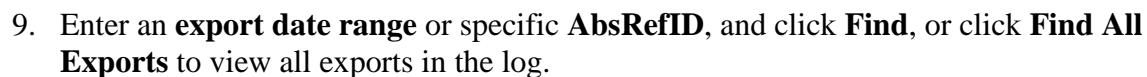
In the example shown below, the export file is being saved as TestExport.txt.

Result: The system saves the abstracts into a text file and lets you preview a report that you can print. By Default, Abstract Plus saves your export files to **C:\RegPlus\AbstractPlus\Exports.**

Report of Export File for Transmit									
Wednesday, May 01, 2013									
File Name: C:\Users\Kathleen\Documents\AbstractPlusWorkbench\Exports\TestEx									
Date Export file created: 05/01/2013									
Abstractor creating file: NAU									
Count of records in file: 1									
Selection used to create report: SELECT RepHosp, AccNumHosp, SeqNumHosp, NameX, PSite, MedRecNum, DateOffLoaded, (Mid(DxDate,1,4) + Mid(DxDate,5,2) + Mid(DxDate,7,2)) as DxDate, (Mid(Date1stCont,1,4) + Mid(Date1stCont,5,2) + Mid(Date1stCont,7,2)) as Date1stCont, (Mid(DtCaseComp,1,4) + Mid(DtCaseComp,5,2) + Mid(DtCaseComp,7,2)) as DtCaseComp FROM Abstracts, Abstracts_2 WHERE IIF(NOT ISNULL(DATEOFFLOADED), CDATE(DATEOFFLOADED), CDATE("01/01/1900")) = #5/1/2013 3:22:59 PM# AND (RecType = 'A' AND Abstracts.AbsRefID = Abstracts_2.AbsRefID) AND COMPLETED = '1' ORDER BY RepHosp, AccNumHosp, SeqNumHosp									
Rep Hosp	Acc Num Hosp	Seq	Name	Medical Rec Num	Primary Site	Diagnosis Date	Date 1st Contact	Case Complete	Date Off Loaded
111111111		00	DOE, JOHN	12312312312	C619	20130223	20130215	20130501	5/1/2013 3:22:59 PM

7. **Close** the report preview and return to the Export Abstracts window.
8. Click **Export Log** to view the log of exported abstracts.

Result: The **Export Log** window opens. Notice that you can enter a date range or enter Select Case ID, and click **Select** to view exports that contain the specified values.



Export Log

Select Export Date Range: [Date Format: YYYY/MM/DD]

☐ Select using Date Range
 From : To:

Selected AbsRefID:

Date	User ID	Abstracts Marked	Export Type	Export Count	
2013/05/01	NAU	Yes	10	1	C:\Users\Ka

Export Type Description:

Selected	Description
<input checked="" type="checkbox"/>	1 - Only Un-Exported
<input type="checkbox"/>	2 - Date Exported Range
<input type="checkbox"/>	3 - Date Created Range
<input type="checkbox"/>	4 - Hospital ID
<input type="checkbox"/>	5 - Abstractor ID
<input type="checkbox"/>	6 - Case ID
<input type="checkbox"/>	7 - Project

Exported Case IDs For: 2013/05/01

Find
 Find All Exports
 Print
 Close
 ?

2

AbsRefID	Abstractor	Name	Rep Hosp	Accession Num	Seq Hosp Num	Primary Sit
2	NAU	DOE, JOHN	111111111		00	C619

- ## 11. To export the file to the MCSP, go to Chapter 6: Submission of Data

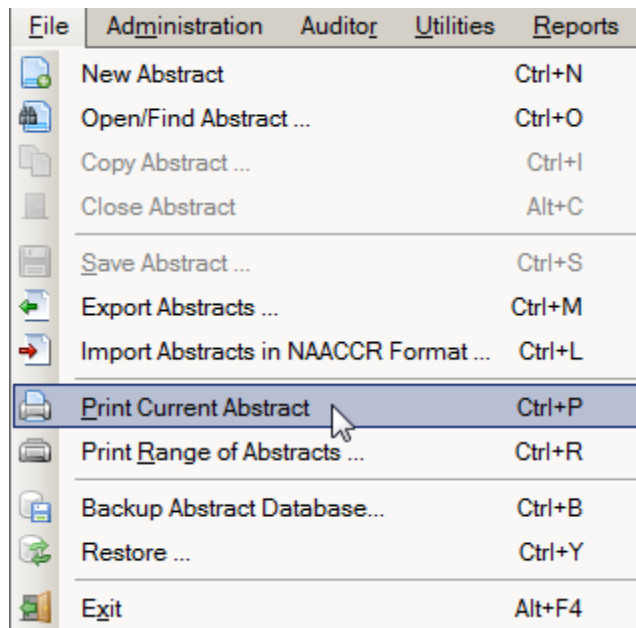
Printing Abstracts

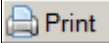
You can print any individual abstract that is open, or you can select one or more abstracts from your local database and print them. You can also choose to print the abstracts to a text file instead of sending them directly to a printer.

Printing an Open Abstract

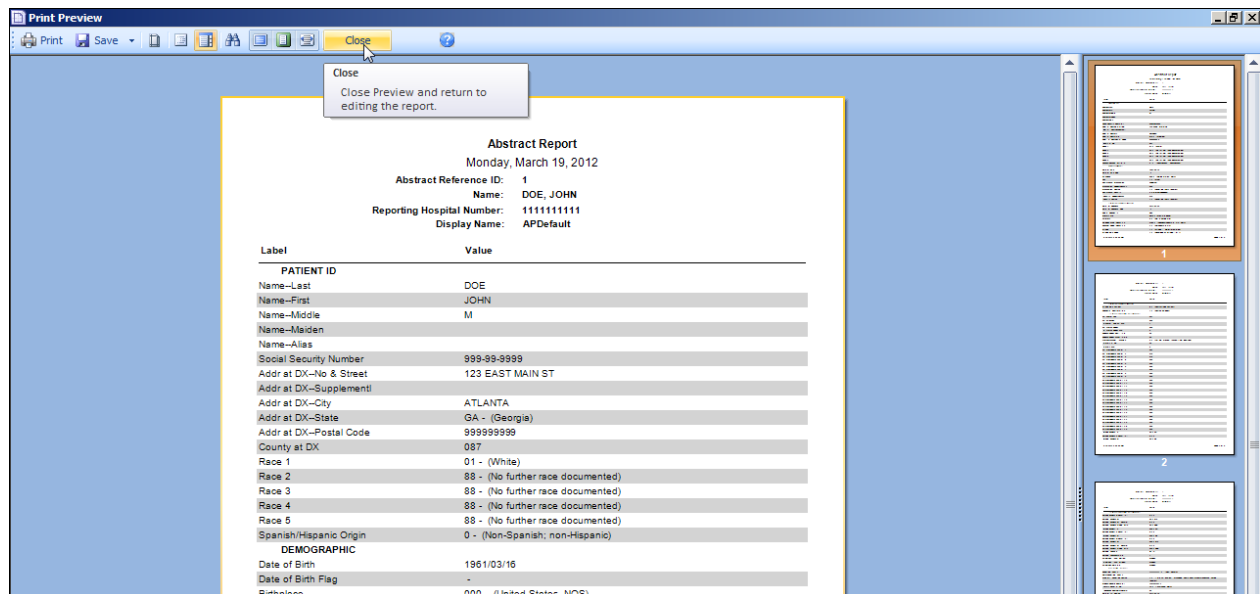
To print an individual abstract that is open, complete these steps:

1. An opened abstract can be printed in 3 ways:
 - a. Click on the **File** menu, and select **Print Current Abstract**.



- b. Click the **Print** icon on the tool bar .
 - c. Use the keystroke **Ctrl+P**.

Result: The Abstract Plus **Report Viewer** window opens with a print preview of the abstract to be printed. Note that for the majority of fields, the coded value and the label are printed. Please see page 202 of this manual or click [here](#) to learn more about using the Report Viewer window to view, save and print reports.

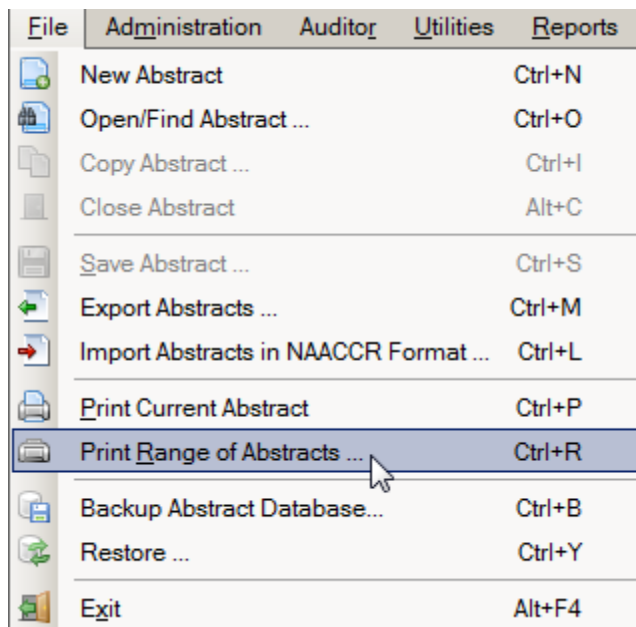


2. Click **Print** or **Save** to print or save the abstract in the format of your choice.
3. When you are done viewing/printing the abstract, click **Close**.

Printing a Range of Abstracts

To print a range of abstracts, complete these steps:

1. Printing a range of abstracts can be done in 2 ways:
 - a. Click on the **File** menu, and select **Print Range of Abstracts**.

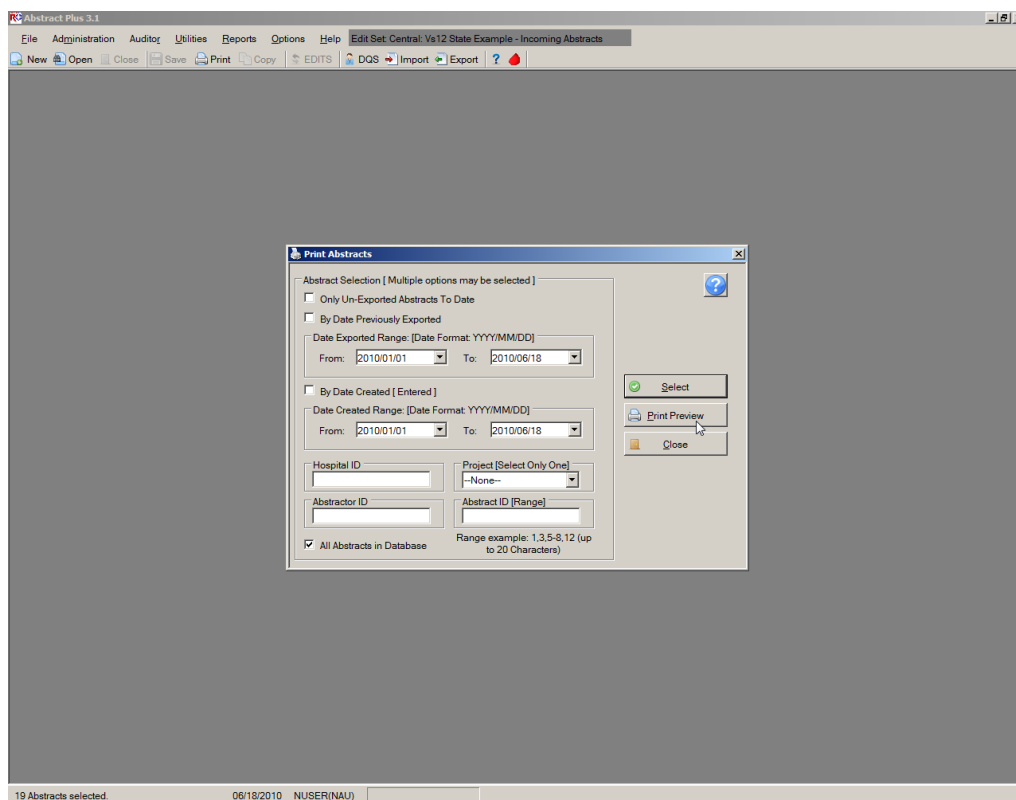


- b. Use the keystroke **Ctrl+R**.

Result: The **Print Abstracts** window opens.

2. Enter the abstract selection criteria for the range of abstracts that you would like to print. You can select the only un-exported Abstracts To Date or All Abstracts in Database options, or you can select abstracts by date previously exported, date created, Facility or Project ID, Abstractor ID or AbsRefID. In the example shown the Select the All Abstracts in Database printing option is checked.
3. Click **Select**.

Result: The system displays the number of abstracts that meet the selected criteria at the bottom of the window.



4. Click **Print Preview**.

Result: The **Report Viewer** window opens with the selected abstracts formatted for printing.

Print Preview

Print Save Close

Abstract Report
Friday, June 18, 2010

Abstract Reference ID: 1
Name: HINKLE, PINKIE
Reporting Hospital Number: 000000001
Display Name: APDefault

Label	Value
PATIENT ID	
Name-Last	HINKLE
Name-First	PINKIE
Name-Middle	M
Name-Maiden	
Name-Alias	
Social Security Number	111-11-5022
Addr at DX--No & Street	BLANK
Addr at DX--Supplement	
Addr at DX--City	ANYWHERE
Addr at DX--State	ZZ - (Residence unknown)
Addr at DX--Postal Code	99999
County at DX	999
Race 1	01 - (White)
Race 2	88 - (No further race documented)
Race 3	88 - (No further race documented)
Race 4	88 - (No further race documented)
Race 5	88 - (No further race documented)
Spanish/Hispanic Origin	0 - (Non-Spanish; non-Hispanic)
DEMOGRAPHIC	
Date of Birth	19430416
Date of Birth Flag	-
Birthplace	071 - (Arkansas)
Sex	2 - (Female)
Text--Usual Occupation	RC TEST PROJECT
Text--Usual Industry	UNK
CANCER IDENTIFICATION	
Date of Diagnosis	20010510
Date of Diagnosis Flag	-
Age at Diagnosis	058
Primary Site	C421 - (Bone marrow)
Laterality	0 - (Not a paired site)
Histologic Type ICD-O-3	9823 - (B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (see also M-9670/3) (C42.1))
Behavior Code ICD-O-3	3 - (Malignant, primary site)
Grade	6 - (B-cell (for lymphomas and leukemias))
Diagnostic Confirmation	1 - (Positive histology)

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1 2 3 4


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- When you are done viewing the report, click **Print** to print the report, **Save** to save the report.
- Click **Close** to close the report.
- Close the Print Abstracts window.

Chapter 4: Using Abstract Plus Utilities

The Utilities menu is used to access a few supplementary functions included in the program, such as querying your local database of doctors, managing facility and doctor codes, and deleting abstracts.

To access the Utilities menu items, click on the **Utilities** menu item and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.

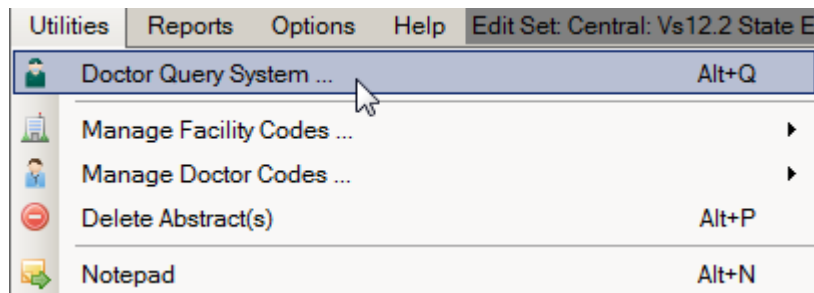
Sub-option (Keystroke)	Toolbar Icon	Function
Doctor Query System (Alt+Q)		Query and search the doctor database; DQS can be accessed whether or not an abstract is opened, or a physician field selected
Manage Facility Codes...		Import (can use Alt+I keystroke) or edit (can use Alt+J keystroke) local facility codes
Manage Doctor Codes...		Import (can use Alt+K keystroke) or edit (can use Alt+L keystroke) local physician codes
Delete Abstract(s) (Alt+P)		Delete selected abstracts
Notepad (Alt+N)		Launch Notepad to view created text files

The Doctor Query System

The Abstract Plus Doctor Query System (DQS) allows you to search your local doctor database. The DQS can be accessed whether or not an abstract is opened, or whether or not you have a physician field selected in the data entry grid.

To open the DQS and search for a doctor, complete these steps:

1. The DQS can be accessed in 2 ways:
 - a. Click on the **Utilities** menu, and select **Doctor Query System**.



- a. Use the keystroke **Alt+Q**.

Result: The Doctor Query System window opens.

Doctor Query System

Search Value(s)

Last Name First Name Doctor ID

Note: Partial name search allowed *Example: 12345678*

Query Results: **No Doctors found.**

Doctor ID	NIP Doctor Code	Name	Address	Specialty
-----------	-----------------	------	---------	-----------

Buttons: Query, Select, Close

- Enter the search criteria of your choice and click **Query**. The DQS can be searched by doctor name or ID.

Result: Doctors meeting the search criteria entered are listed in the lower portion of the window.

Doctor Query System

Search Value(s)

Last Name First Name Doctor ID

Note: Partial name search allowed *Example: 12345678*

Query Results: **13 Doctors found.**

Doctor ID	NIP Doctor Code	Name	Address	Specialty
933		Bedoya, Alfonso	330 Kildare Pl, Glen Burnie, MD 96940	SURGERY
967		Bobula, Anne	Box 18 County Road, Baltimore, MD 99933	SURGERY
10000001		Fawn, Terry	125 Main St, PO Box 222 Northside, GA 33345	Internal Medicine
922		Jones, James	222 Hospital Drive, Washington, DC 97300	PRIMARY HEALTH
20000002		Jones, James	456 Another Street, Atlanta, GA 30301	Pediatrics
945		Kim, Sun	18 Embolism Terrace, Ashtabula, OH 94444	GYNECOLOGY
99999999		NO CODE,	.	
999		Northcutt, Marshall	PO Box 777, Fulton, NY 90001	GENERAL SURGERY
966		Redfern, Belinda	1 Welby Center, El Paso, TX 90020	GYNECOLOGY
980		Regaldo, Francesca	One Profit Center, Atlanta, GA 93399	GENERAL SURGERY

Buttons: Query, Select, Close

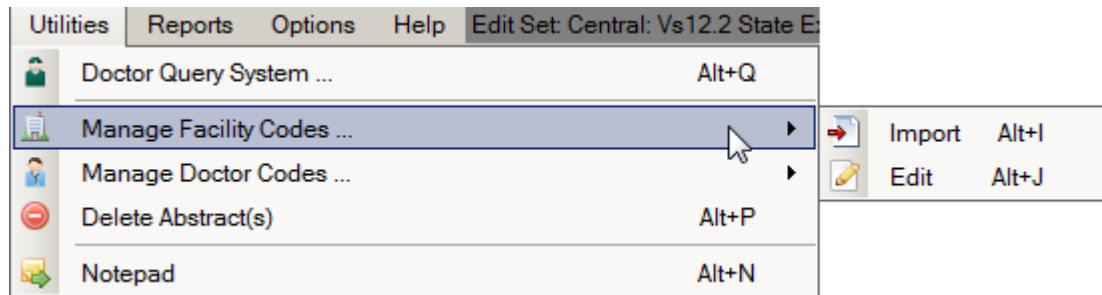
- When you have finished look-up doctor codes, click **Close** to close the DQS window.

Managing Facility Codes

Abstract Plus allows you to manage codes for facilities. The initial list of facility codes is added to the application by your Abstract Plus Administrator, however, you can add or delete individual facilities to or from the list.

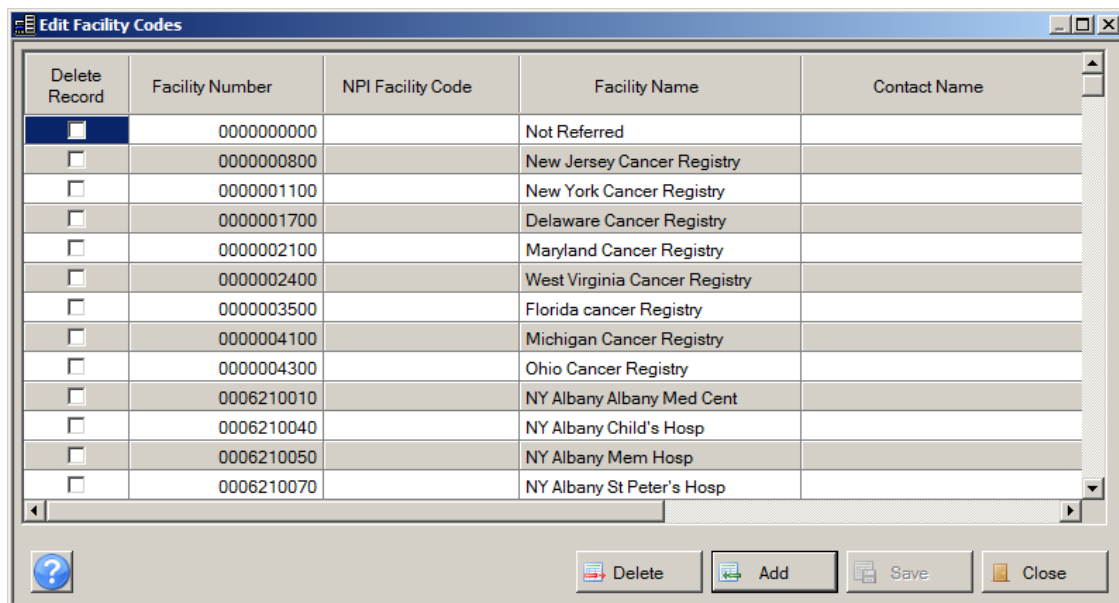
To manage facility codes, complete these steps:

1. You can manage facility codes in 2 ways:
 - a. Click on the **Utilities** menu, and select **Manage Facility Codes**.

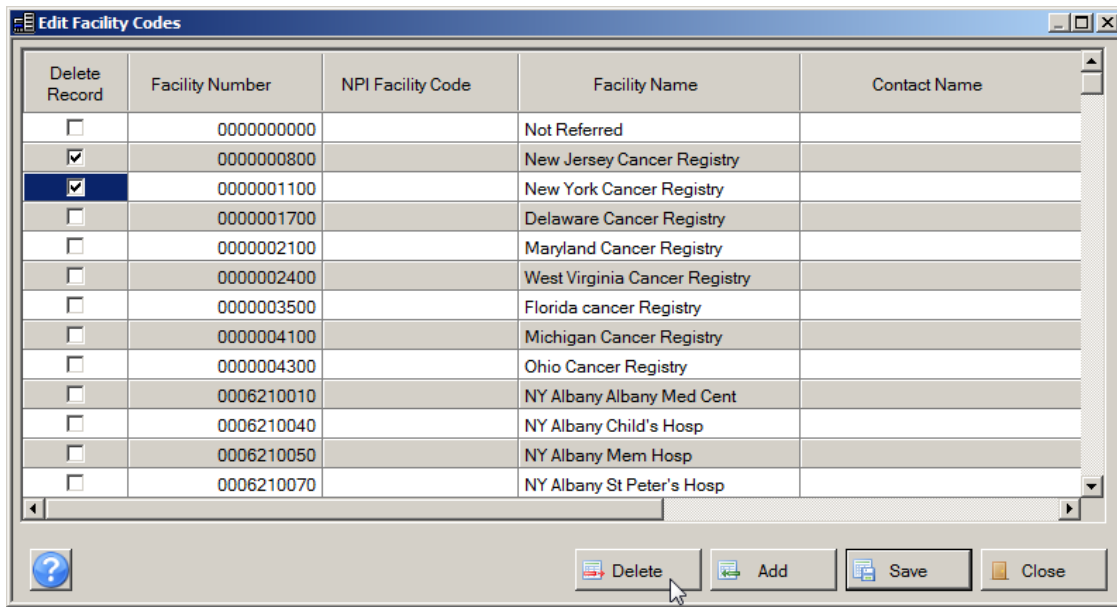


- b. Use the keystroke **Alt+J**.

Result: The **Edit Facility Codes** window opens.



2. To delete a facility or facilities from the list, check the **Delete Record** check box for the row of the facility or facilities that you would like to delete.



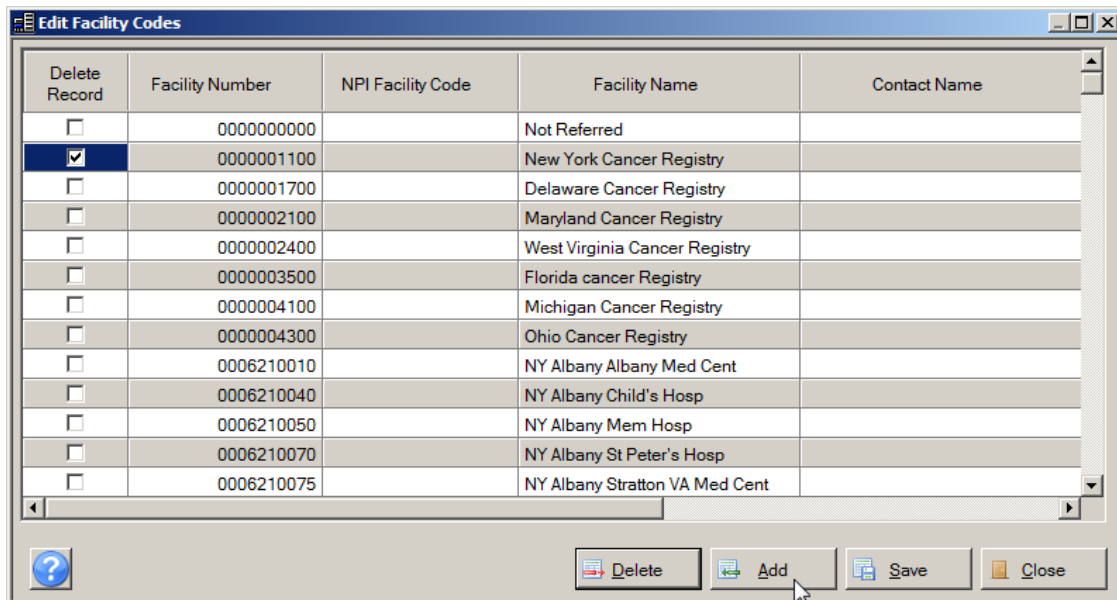
Delete Record	Facility Number	NPI Facility Code	Facility Name	Contact Name
<input type="checkbox"/>	0000000000		Not Referred	
<input checked="" type="checkbox"/>	0000000800		New Jersey Cancer Registry	
<input checked="" type="checkbox"/>	0000001100		New York Cancer Registry	
<input type="checkbox"/>	0000001700		Delaware Cancer Registry	
<input type="checkbox"/>	0000002100		Maryland Cancer Registry	
<input type="checkbox"/>	0000002400		West Virginia Cancer Registry	
<input type="checkbox"/>	0000003500		Florida cancer Registry	
<input type="checkbox"/>	0000004100		Michigan Cancer Registry	
<input type="checkbox"/>	0000004300		Ohio Cancer Registry	
<input type="checkbox"/>	0006210010		NY Albany Albany Med Cent	
<input type="checkbox"/>	0006210040		NY Albany Child's Hosp	
<input type="checkbox"/>	0006210050		NY Albany Mem Hosp	
<input type="checkbox"/>	0006210070		NY Albany St Peter's Hosp	

Buttons: Delete, Add, Save, Close

- Click **Delete**.

Result: The facility or facilities selected for deletion are deleted from the list.

- To add a facility or facilities to the list, click **Add**.



Delete Record	Facility Number	NPI Facility Code	Facility Name	Contact Name
<input type="checkbox"/>	0000000000		Not Referred	
<input checked="" type="checkbox"/>	0000001100		New York Cancer Registry	
<input type="checkbox"/>	0000001700		Delaware Cancer Registry	
<input type="checkbox"/>	0000002100		Maryland Cancer Registry	
<input type="checkbox"/>	0000002400		West Virginia Cancer Registry	
<input type="checkbox"/>	0000003500		Florida cancer Registry	
<input type="checkbox"/>	0000004100		Michigan Cancer Registry	
<input type="checkbox"/>	0000004300		Ohio Cancer Registry	
<input type="checkbox"/>	0006210010		NY Albany Albany Med Cent	
<input type="checkbox"/>	0006210040		NY Albany Child's Hosp	
<input type="checkbox"/>	0006210050		NY Albany Mem Hosp	
<input type="checkbox"/>	0006210070		NY Albany St Peter's Hosp	
<input type="checkbox"/>	0006210075		NY Albany Stratton VA Med Cent	

Buttons: Delete, Add, Save, Close

Result: The application directs you to a new row into which you can enter information for the facility such as the facility name and number and add the facility to the list.

Delete Record	Facility Number	NPI Facility Code	Facility Name	Contact Name
<input type="checkbox"/>	0010000005		PA Pittsburgh Jefferson Rad Onc Ctr	
<input type="checkbox"/>	0010000063		PA Erie The Regional Cancer Center	
<input type="checkbox"/>	0010000140		PA Harrisburg Greater Hbg Cancer Ctr	
<input type="checkbox"/>	0010000141		PA Lebanon Lebanon Valley Cancer Center	
<input type="checkbox"/>	0099999999		Unknown	
<input type="checkbox"/>	1111111111		Test Hospital	
<input type="checkbox"/>	2345678901		Second Hospital	Jean Harris
<input type="checkbox"/>	8989898989		Third Hospital	Tom Jones
<input type="checkbox"/>				

Buttons: ? Delete Add Save Close

5. At a minimum, enter the facility name and number, and then click **Save**.

Delete Record	Facility Number	NPI Facility Code	Facility Name	Contact Name
<input type="checkbox"/>	0010000005		PA Pittsburgh Jefferson Rad Onc Ctr	
<input type="checkbox"/>	0010000063		PA Erie The Regional Cancer Center	
<input type="checkbox"/>	0010000140		PA Harrisburg Greater Hbg Cancer Ctr	
<input type="checkbox"/>	0010000141		PA Lebanon Lebanon Valley Cancer Center	
<input type="checkbox"/>	0099999999		Unknown	
<input type="checkbox"/>	1111111111		Test Hospital	
<input type="checkbox"/>	2345678901		Second Hospital	Jean Harris
<input type="checkbox"/>	8989898989		Third Hospital	Tom Jones
<input type="checkbox"/>	2222222222		Test Facility 2	
<input type="checkbox"/>				

Buttons: ? Delete Add Save Close

Result: The facility is added to the list.

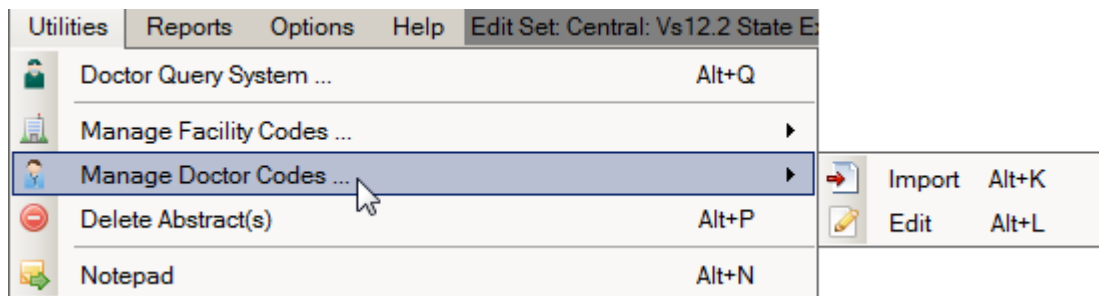
6. When you are one editing facility codes, click **Close**.

Managing Doctor Codes

Abstract Plus also allows you to manage codes for doctors. The initial list of doctor codes is added to the application by your Abstract Plus Administrator, however, you can add or delete individual doctors to or from the list.

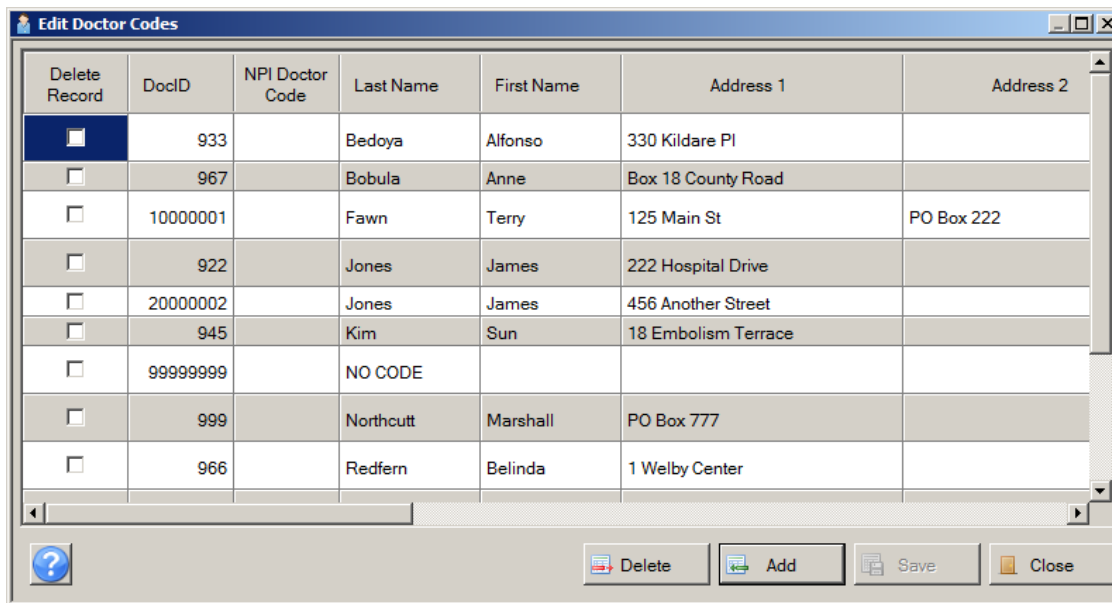
To manage doctor codes, complete these steps:

1. You can manage doctor codes in 2 ways:
 - a. Click on the **Utilities** menu, and select **Manage Doctor Codes**.

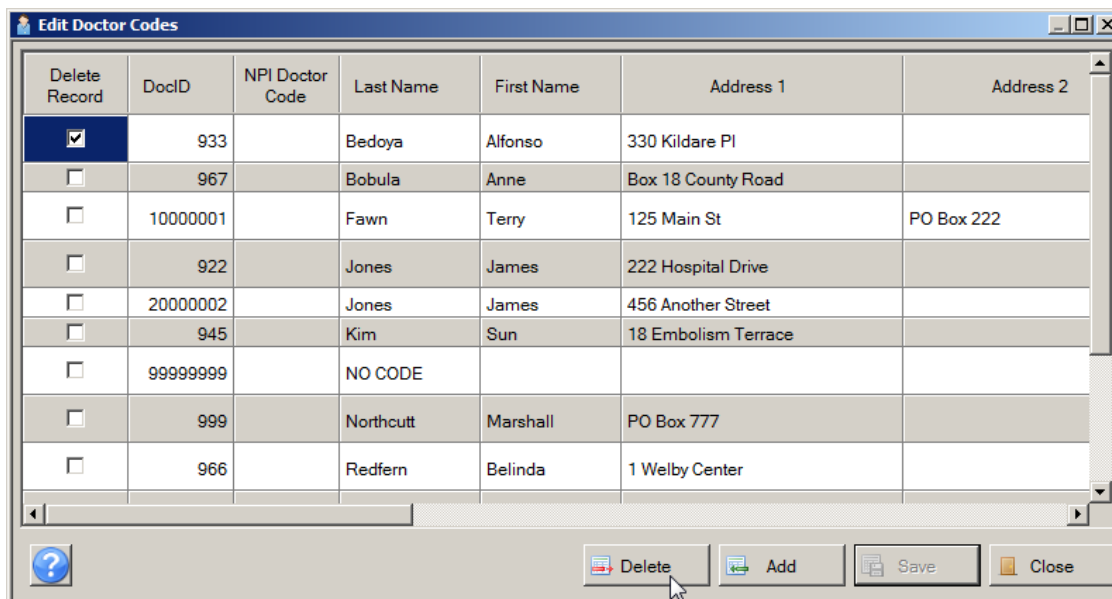


b. Use the keystroke **Alt+L**.

Result: The **Edit Doctor Codes** window opens.



- To delete a doctor or doctors from the list, check the **Delete Record** check box for the row of the doctor or doctors that you would like to delete, and click **Delete**.



Result: The doctor or doctors selected for deletion are deleted from the list.

- To add a doctor to the list, click **Add**.

The screenshot shows the 'Edit Doctor Codes' window with a table of doctor information. The 'Add' button is highlighted with a mouse cursor.

Delete Record	DocID	NPI Doctor Code	Last Name	First Name	Address 1	Address 2
<input checked="" type="checkbox"/>	967		Bobula	Anne	Box 18 County Road	
<input type="checkbox"/>	10000001		Fawn	Terry	125 Main St	PO Box 222
<input type="checkbox"/>	922		Jones	James	222 Hospital Drive	
<input type="checkbox"/>	20000002		Jones	James	456 Another Street	
<input type="checkbox"/>	945		Kim	Sun	18 Embolism Terrace	
<input type="checkbox"/>	99999999		NO CODE			
<input type="checkbox"/>	999		Northcutt	Marshall	PO Box 777	
<input type="checkbox"/>	966		Redfern	Belinda	1 Welby Center	
<input type="checkbox"/>	980		Regaldo	Francesca	One Profit Center	

Buttons: ? Delete Add Save Close

Result: The application directs you to a new row into which you can enter information for the doctor such as the doctor name and number and add the doctor to the list.

- At a minimum, enter the doctor name and number, and then click **Save**.

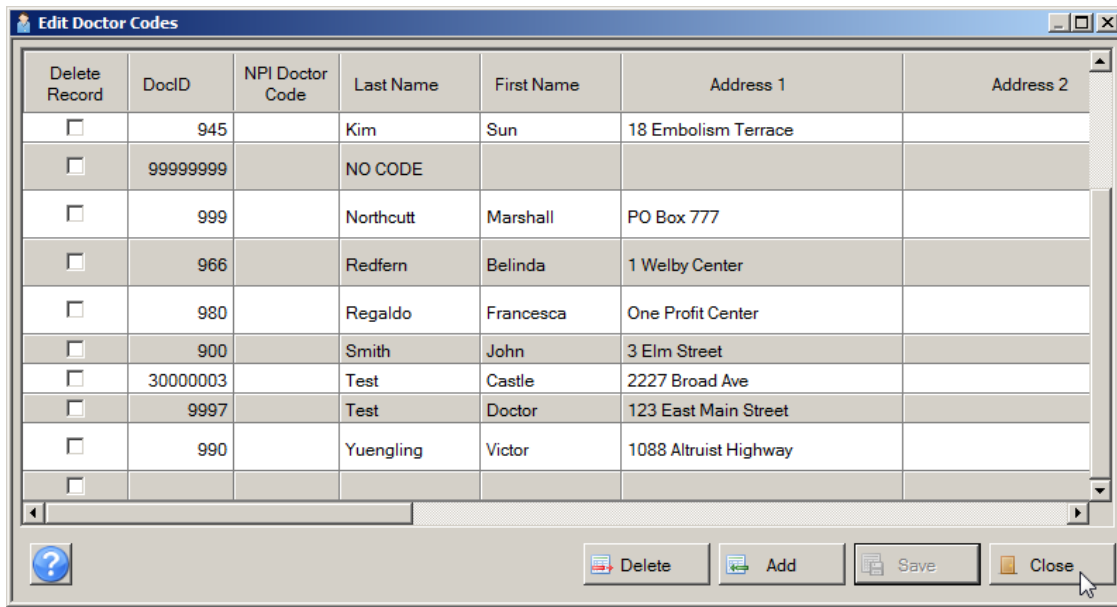
Result: The doctor is added to the list.

The screenshot shows the 'Edit Doctor Codes' window with the updated list of doctors. The 'Save' button is highlighted with a mouse cursor.

Delete Record	DocID	NPI Doctor Code	Last Name	First Name	Address 1	Address 2
<input type="checkbox"/>	20000002		Jones	James	456 Another Street	
<input type="checkbox"/>	945		Kim	Sun	18 Embolism Terrace	
<input type="checkbox"/>	99999999		NO CODE			
<input type="checkbox"/>	999		Northcutt	Marshall	PO Box 777	
<input type="checkbox"/>	966		Redfern	Belinda	1 Welby Center	
<input type="checkbox"/>	980		Regaldo	Francesca	One Profit Center	
<input type="checkbox"/>	900		Smith	John	3 Elm Street	
<input type="checkbox"/>	30000003		Test	Castle	2227 Broad Ave	
<input type="checkbox"/>	990		Yuengling	Victor	1088 Altruist Highway	
<input type="checkbox"/>	9997		Test	Doctor	123 East Main Street	

Buttons: ? Delete Add Save Close

- When you are done editing doctor codes, click **Close**.

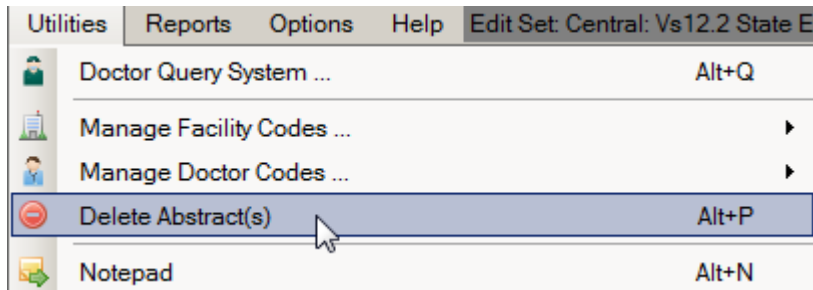


Deleting Abstracts

Abstract Plus allows you to delete abstracts from the abstract database. This feature should be used with caution, as abstracts are permanently deleted from the database.

To delete an abstract, complete these steps:

1. Abstracts can be deleted in 2 ways:
 - a. Click on the **Utilities** menu, and select **Delete Abstract(s)**.



- b. Use the keystroke **Alt+P**.

Result: The **Delete Abstracts** window opens.

Delete Abstracts

Query Items [Multiple item selection allowed]

☒ All ☐ Complete Abstracts Only ☐ Incomplete Abstracts Only

Item Value

Last Name: First Name: Abstracted By:
Note: Partial name search allowed *Example: DOE*

Abstract ID: To: Date Exported: Reporting Hospital:
Example: 1234567890 *Example: 2008/12/15 (YYYY/MM/DD)* *Example: 12345678901*

☐ Select/Deselect All

Buttons: Query, Delete, Close

Query Results: Ready ...

Delete Case	Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp
-------------	------	-------------	---------------	-------------------	-----	--------------	--------------

- Abstracts to be deleted can be searched for via various search criteria: patient name, Abstractor's initials, Abstract Reference ID, Reporting Facility, and export date.
- Enter your search criteria, and click **Query**. In the example shown, the abstract for the patient named John Doe is being searched for and deleted, so a D is entered in the patient Last Name box.

Result: Abstracts that match the specified search criteria are displayed in the lower portion of the window. Note that all abstracts listed are selected for deletion. In the example shown, all patient abstracts with the last name beginning with D are displayed and selected for deletion.

Delete Abstracts

Query Items [Multiple item selection allowed]

☒ All ☐ Complete Abstracts Only ☐ Incomplete Abstracts Only

Item Value

Last Name: First Name: Abstracted By:
Note: Partial name search allowed *Example: DOE*

Abstract ID: To: Date Exported: Reporting Hospital:
Example: 1234567890 *Example: 2008/12/15 (YYYY/MM/DD)* *Example: 12345678901*

☒ Select/Deselect All

Buttons: Query, Delete, Close

Query Results: 7 Abstracts found.

Delete Case	Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp
<input checked="" type="checkbox"/>	DANCER, CANDY	4	19200419	111-11-5015	Female	200100506	01
<input checked="" type="checkbox"/>	DAYS, HAPPY	12	19351022	111-11-5016	Female	200101067	02
<input checked="" type="checkbox"/>	DAYS, HAPPY	11	19351022	111-11-5016	Female	200101067	01
<input checked="" type="checkbox"/>	DOE, JOHN	19	19610316	999-99-9999	Male		
<input checked="" type="checkbox"/>	DOE, JOHN	18	19610316	999-99-9999	Male		00
<input checked="" type="checkbox"/>	DRIVER, CABBY	14	19330318	111-11-1078	Male	200101078	04
<input checked="" type="checkbox"/>	DRIVER, CABBY	13	19330318	111-11-1078	Male	200101078	03

- To select an individual abstract for deletion from the displayed list, click **Select/Deselect All**.

Result: All abstracts in the window are deselected.

- Select individual abstracts for deletion by checking the **Delete Case** check box for the abstract(s), and clicking **Delete**.

Delete Case	Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp
<input type="checkbox"/>	DANCER, CANDY	4	19200419	111-11-5015	Female	200100506	01
<input type="checkbox"/>	DAYS, HAPPY	12	19351022	111-11-5016	Female	200101067	02
<input type="checkbox"/>	DAYS, HAPPY	11	19351022	111-11-5016	Female	200101067	01
<input checked="" type="checkbox"/>	DOE, JOHN	19	19610316	999-99-9999	Male		
<input type="checkbox"/>	DOE, JOHN	18	19610316	999-99-9999	Male		00
<input type="checkbox"/>	DRIVER, CABBY	14	19330318	111-11-1078	Male	200101078	04
<input type="checkbox"/>	DRIVER, CABBY	13	19330318	111-11-1078	Male	200101078	03

Result: The system verifies that you would like to delete the selected abstract(s), and creates a backup database.

- Click **Yes**.

Result: The system lets you know that the abstract has been deleted.

- Click **OK**.

Result: You are returned to the Delete Abstracts window, where the abstract(s) has been deleted from the list.

Delete Abstracts

Query Items [Multiple item selection allowed]

☒ All ☐ Complete Abstracts Only ☐ Incomplete Abstracts Only

Item Value

Last Name: First Name: Abstracted By:

Note: Partial name search allowed *Example: DOE*

Abstract ID: To: Date Exported: Reporting Hospital:

Example: 1234567890 *Example: 2008/12/15 (YYYY/MM/DD)* *Example: 12345678901*

☒ Select/Deselect All

Query Results: 6 Abstracts found.

Delete Case	Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp	
<input checked="" type="checkbox"/>	DANCER, CANDY	4	19200419	111-11-5015	Female	200100506	01	
<input checked="" type="checkbox"/>	DAYS, HAPPY	12	19351022	111-11-5016	Female	200101067	02	
<input checked="" type="checkbox"/>	DAYS, HAPPY	11	19351022	111-11-5016	Female	200101067	01	
<input checked="" type="checkbox"/>	DOE, JOHN	18	19610316	999-99-9999	Male		00	
<input checked="" type="checkbox"/>	DRIVER, CABB	14	19330318	111-11-1078	Male	200101078	04	
<input checked="" type="checkbox"/>	DRIVER, CABB	13	19330318	111-11-1078	Male	200101078	03	

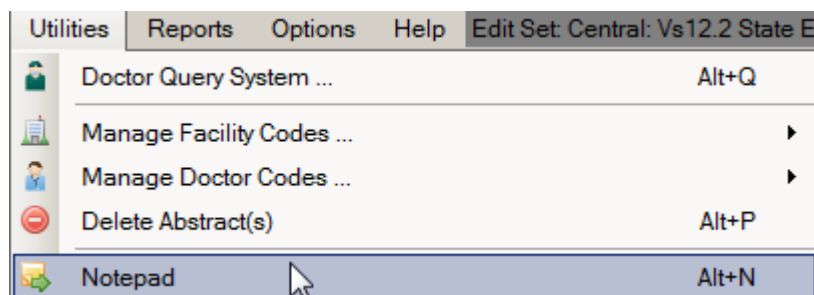
8. When you have finished deleting abstracts click **Close** to close the Delete Abstracts window.

Using the Notepad Function

The Notepad program is integrated into Abstract Plus under the Utilities menu. Notepad allows you to view the contents of a file using the Notepad program without having to navigate away from Abstract Plus.

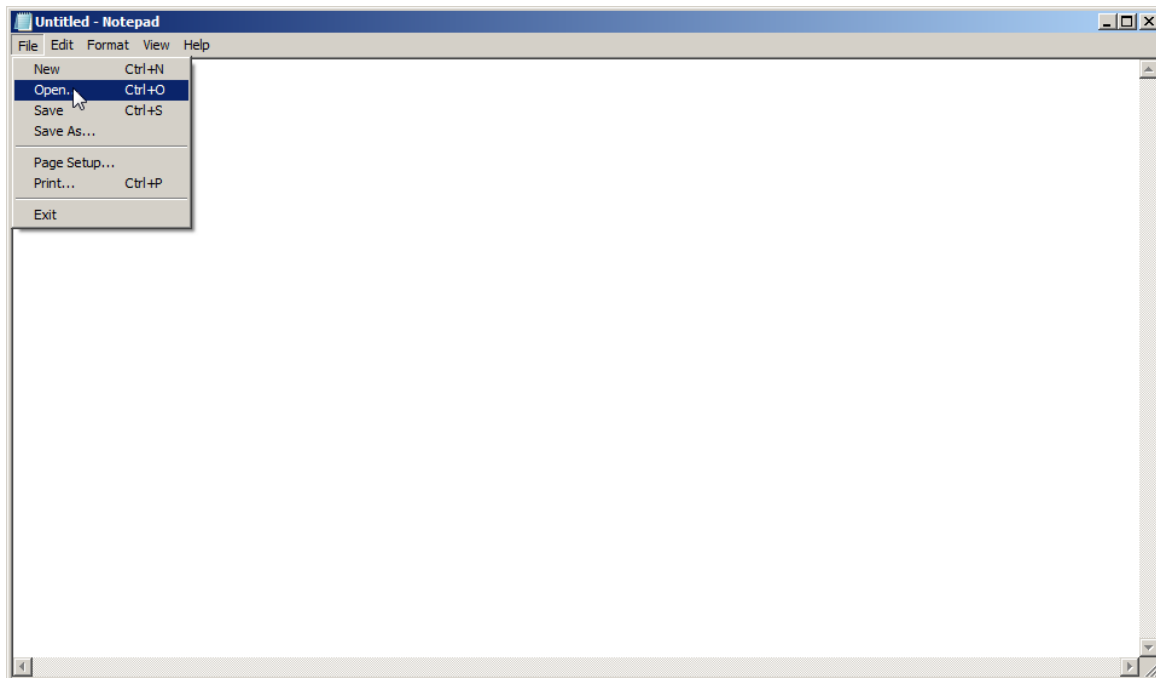
To use the Notepad feature, complete these steps:

1. The Notepad feature can be opened in 2 ways:
 - a. Click on the **Utilities** menu, and select **Notepad**.



- b. Use the keystroke **Alt+N**.

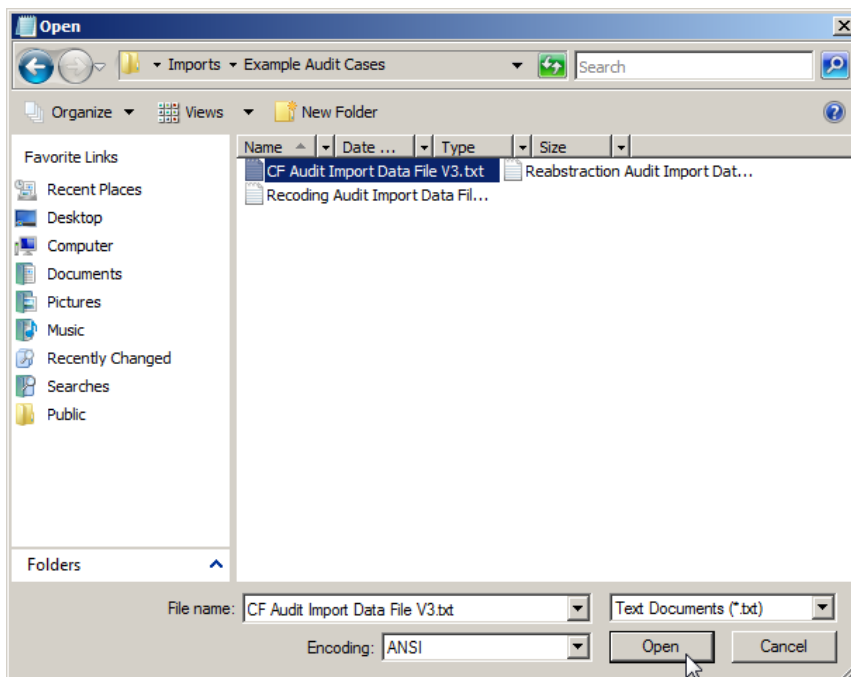
Result: Notepad opens.



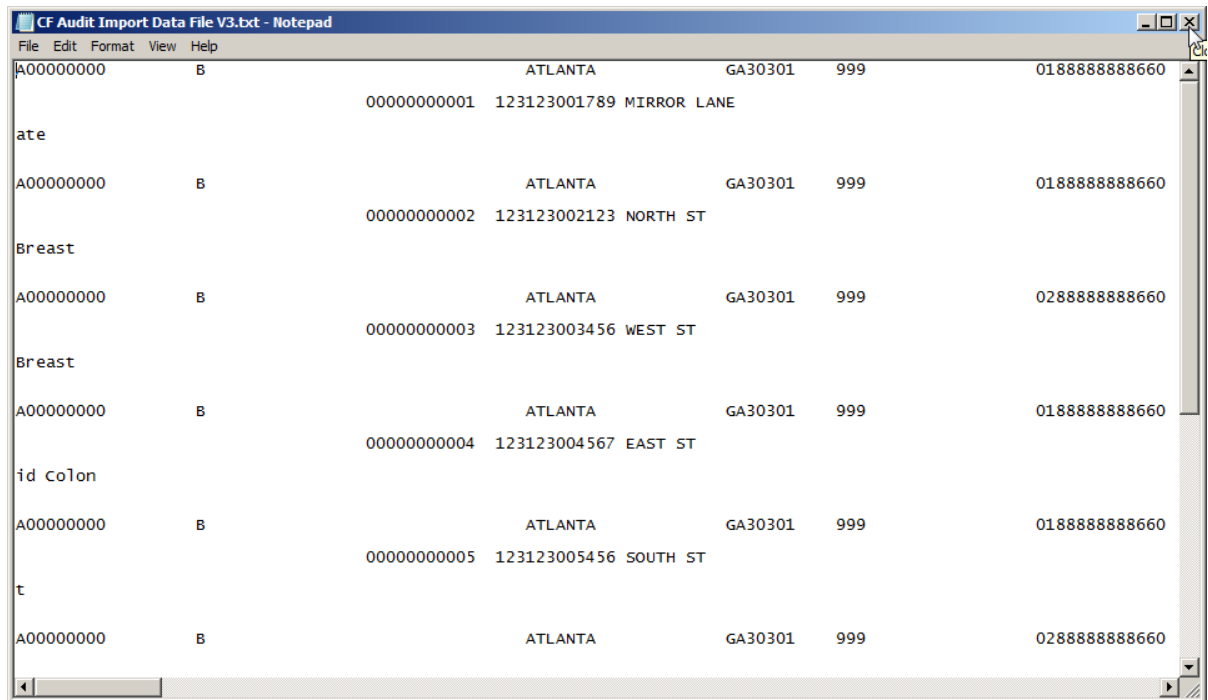
2. Click **File** on the Notepad menu and select **Open**.

Result: An Open file windows dialog box opens.

3. Navigate to the folder and text file that you would like to open, and click **Open**.



Result: The selected file opens in Notepad.



A00000000	B	ATLANTA	GA30301	999	0188888888660	ate
		00000000001	123123001789	MIRROR LANE		
A00000000	B	ATLANTA	GA30301	999	0188888888660	Breast
		00000000002	123123002123	NORTH ST		
A00000000	B	ATLANTA	GA30301	999	0288888888660	Breast
		00000000003	123123003456	WEST ST		
A00000000	B	ATLANTA	GA30301	999	0188888888660	id colon
		00000000004	123123004567	EAST ST		
A00000000	B	ATLANTA	GA30301	999	0188888888660	t
		00000000005	123123005456	SOUTH ST		
A00000000	B	ATLANTA	GA30301	999	0288888888660	

4. When you are done viewing the contents of the file, **close** Notepad.

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Chapter 5: Running Reports

Learning Objectives

In this chapter, you will learn to:

- Identify the different reports you can run using Abstract Plus
- Open an Abstract Plus report, and use the various Report Viewer window options to maximize your report viewing experience
- Become familiar with the all of the different file formats in which reports can be saved

Overview

This chapter covers general information about Abstract Plus reports. It includes a description of all abstract reports offered by the application, how to open the reports, how to use the Report Viewer window, and how to print and save reports.

Available Reports

The abstracting features of Abstract Plus are supported by a few standard, easy-to-understand reports that can help facilitate and track abstracting activities. The reports included can be upon request using the Reports menu item. The available abstract reports are described in the table below.

Report	Description
Accession Register	Includes a line listing of all abstracts in the database, sorted by reporting hospital and accession number
Patient Index	Includes a line listing of all abstracts in the database, sorted alphabetically by name
Selected Cases	Line listing report which includes abstracts based on user-specified criteria
Status Report (Count of Cases) Summary...	Includes the total number of complete and incomplete abstracts by export status within a user-specified date range
Completion Status of Abstracts by month	Includes abstract completion status by year and month of Date of Adm/1 st Contact within a user-specified date range

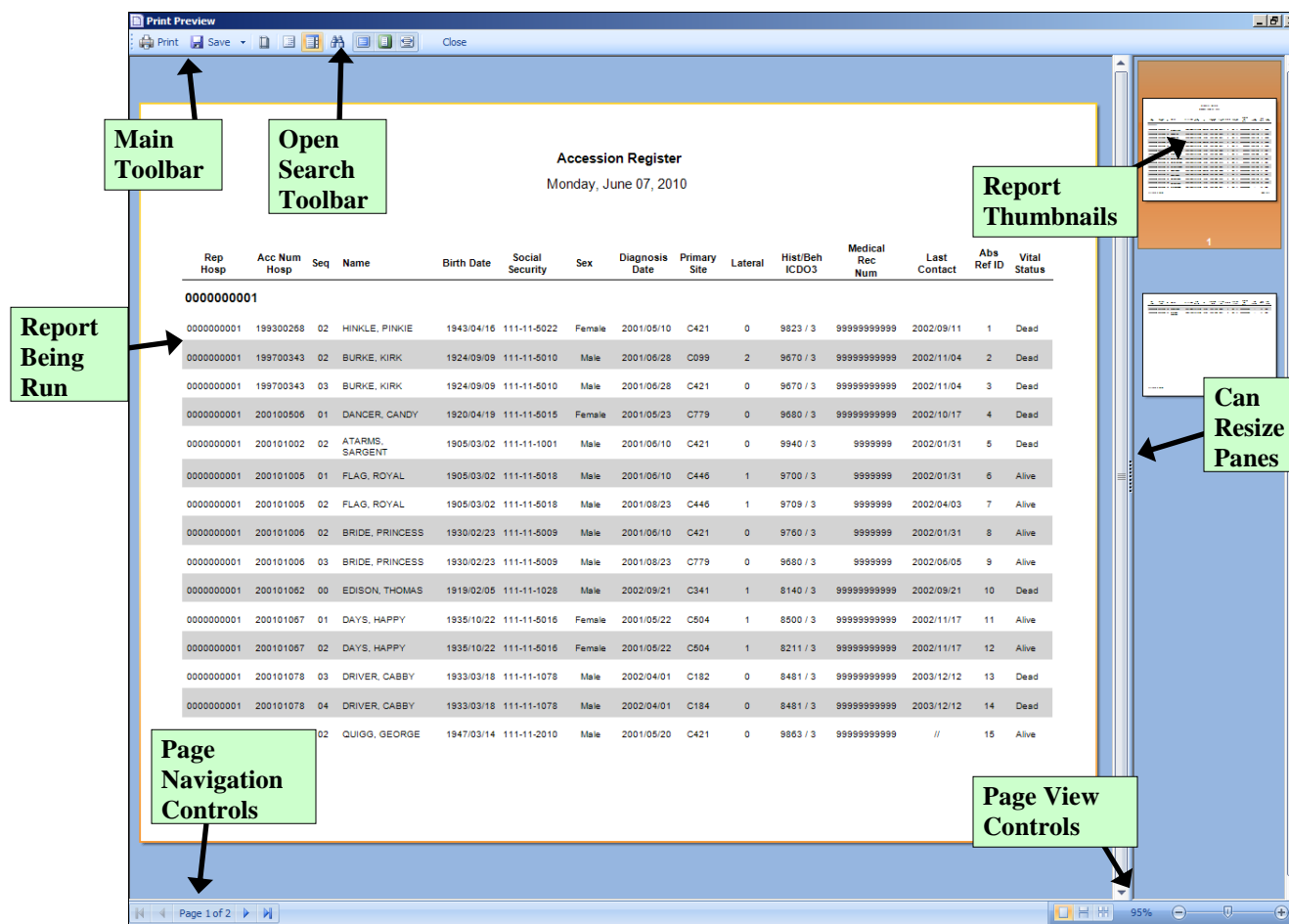
Opening Reports

To open any of the various abstract reports, complete these steps:

1. All abstract reports can be opened in 2 ways:
 - a. Click on the **Reports** menu, and select the report of interest.
 - b. Use the appropriate **keystroke** designated on the Reports menu to open the report of interest. For example, to open the Accession Register Report, use the keystroke Alt+Shift+A.

Result: The report of interest opens in the Abstract Plus **Report Viewer** window.

Viewing Reports – The Report Viewer Window














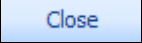
The Abstract Plus Report Viewer window is divided into 2 main sections: a window in which to view reports on the left, and a pane for viewing report thumbnails on the right. When you left-click and hold your mouse on the vertical divider bar in the center of the window, a splitter appears which you can drag to the left or right to resize the view report and thumbnails views.

The Main Toolbar

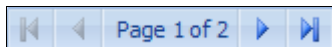


The Report Viewer Main Toolbar includes icons to print and save the report being viewed, as well as modify the current view of the report. The following table describes the function of each of the icons on the Main Toolbar, as well as listing keystroke equivalents where available for each function.



Icon	Keystroke	Function
	Ctrl+P	Print the report being viewed; opens the print dialog window

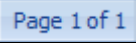


Icon	Keystroke	Function
	Ctrl+O	Save the report being viewed to various file formats
	Ctrl+Shift+S	Change report page setup: size, orientation and margins
	Ctrl+B	Show/hide the tree of bookmarks of the report being viewed; bookmarks are displayed by default---if there are no bookmarks in the report the Report Viewer will automatically hide the tree of bookmarks
	Ctrl+T	Show/hide the thumbnail view of reports in the pane on the right
	Ctrl+F	Search; Open the Search Toolbar
	F2	View the report in full screen mode
	F3	View the report one page at-a-time
	F4	View the report 2 pages at-a-time
	No keystroke	View multiple pages of the report at-a-time; specify 1x2, 2x3, etc.
	F5	Control page width; when clicked report will enlarge to the page width of Report Viewer window
	No keystroke	Close a report

Page Navigation Controls




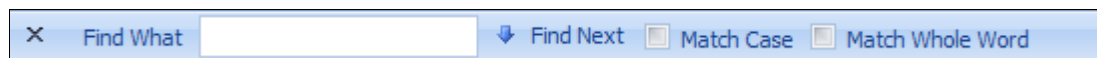
Report page navigation controls are located in the lower left-hand corner of the Report Viewer window and help you navigate through the various pages of the report being viewed. The following table describes the function of each of the page navigation controls.

Control	Function
	View the first page of the report being viewed
	View the previous page of the report being viewed


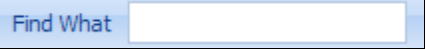

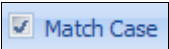
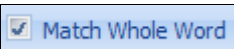
Control	Function
	Lists the page number of the current page of the report being viewed
	View the next page of the report being viewed
	View the last page of the report being viewed

The Search Toolbar

The search panel is used to search for specific text within the report. To access feature, click the binocular icon  on the main toolbar.







When opened, the Search Toolbar is located in the lower left-hand corner of the Report Viewer window directly over the Page Navigation controls. The following table describes the function of each of the Search toolbar icons.

Icon	Function
	Closes the Search Toolbar
	Enter the term being searched for in the Find What box
	When clicked, searches the report and finds the next occurrence of the search term entered in the Find What box
	When checked, the search is repeated with case of the search term considered
	When checked, the search is repeated with only whole words of the search term considered

Page View Controls



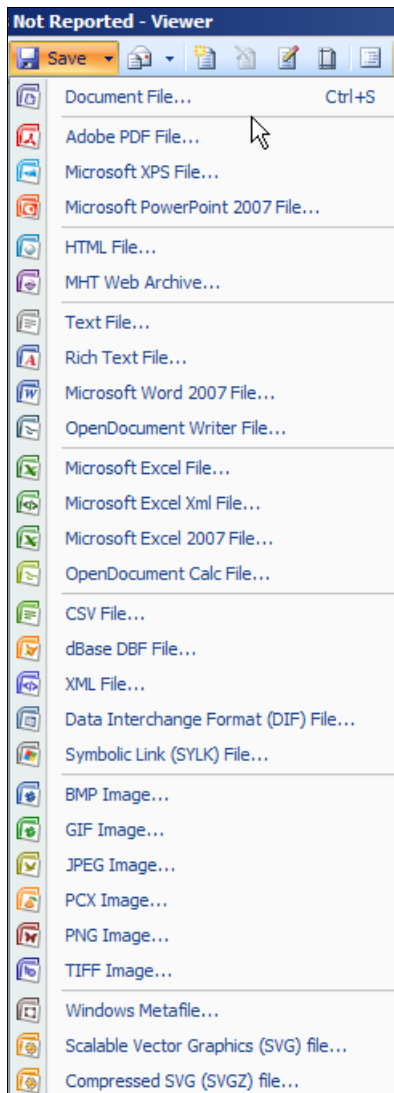
Report page view controls are located in the lower right-hand corner of the Report Viewer window, and include icons to help you control how many pages of the report to view, as well as to zoom in or out on the current report being viewed. The following table describes the function of each of the page view controls.

Control	Keystroke	Function
	Shift+F2	Single Page: View the report one page at-a-time
	Shift+F3	Continuous: View the report with all pages displayed continuously
	Shift+F4	Multiple Pages: based on the selected zoom, all possible pages are displayed to fill the viewer window
	No keystroke	Selected Zoom: View the report at the percent size specified

Saving Reports

In order to facilitate the utilization of the information included in the Abstract Plus reports, Abstract Plus offers an extensive number of file formats in which the reports can be saved. You can save the reports in different file formats in order to further analyze or format the data included differently, or you can save the report as an image file to be placed in documents and presentations.

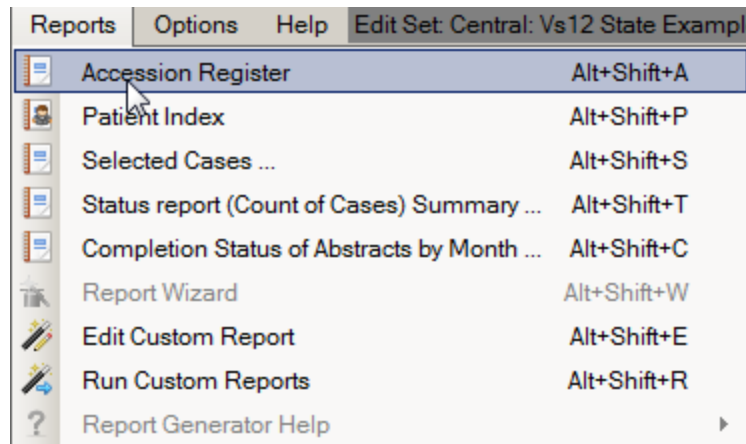
You can save your audit report in any of the file formats listed under the Save As icon on the Main Toolbar of the Report Viewer:



Accession Register Report

To run the Accession Register report, complete these steps:

1. The Accession Register report can be opened in 2 ways:
 - a. Click on the **Reports** menu, and select **Accession Register**.



b. Use the keystroke **Alt+Shift+A**.

Result: The **Accession Register** report opens in the Report Viewer window. Notice that the accession numbers are displayed in ascending order and grouped by the reporting hospital.

Accession Register														
Tuesday, May 07, 2013														
Rep Hosp	Acc Num Hosp	Seq	Name	Birth Date	Social Security	Sex	Diagnosis Date	Primary Site	Lateral	Hist/Beh ICDO3	Medical Rec Num	Last Contact	Abs Ref ID	Vital Status
0000000001														
0000000001	200101005	01	FLAG, ROYAL	19050302	111-11-5018	Male	20010610	C445	1	9700 / 3	9999999	20020131	15	Alive
0000000001	200101005	02	FLAG, ROYAL	19050302	111-11-5018	Male	20010623	C445	1	9709 / 3	9999999	20020403	16	Alive
0000000001	200101006	02	BRIDE, PRINCESS	19300223	111-11-5009	Male	20010610	C421	0	9760 / 3	9999999	20020131	17	Alive
0000000001	200101006	03	BRIDE, PRINCESS	19300223	111-11-5009	Male	20010623	C779	0	9680 / 3	9999999	20020605	18	Alive
0000000001	200101062	00	EDISON, THOMAS	19190205	111-11-1028	Male	20020921	C341	1	8140 / 3	9999999999	20020921	19	Dead
0000000001	200101067	01	DAYS, HAPPY	19351022	111-11-5016	Female	20010522	C504	1	8500 / 3	9999999999	20021117	20	Alive
0000000001	200101067	02	DAYS, HAPPY	19351022	111-11-5016	Female	20010522	C504	1	8211 / 3	9999999999	20021117	21	Alive
0000000001	200101078	03	DRIVER, CABBY	19330318	111-11-1078	Male	20020401	C182	0	8481 / 3	9999999999	20031212	22	Dead
0000000001	200101078	04	DRIVER, CABBY	19330318	111-11-1078	Male	20020401	C184	0	8481 / 3	9999999999	20031212	23	Dead
0000000001	200102023	02	QUIGG, GEORGE	19470314	111-11-2010	Male	20010520	C421	0	9883 / 3	9999999999		24	Alive
0000000001	200102030	00	TYSON, JOHN	19310416	111-11-2013	Male	20010115	C649	2	8312 / 3	9999999999		25	Alive
0000000001	200102033	01	MORTON, THEODOR	19431103	111-11-2014	Male	20010527	C421	0	9861 / 3	9999999999		26	Alive
1111111111														
1111111111		00	DOE, JOHN	19610316	999-99-9999	Male	20130223	C619	0	8140 / 2	12312312312	20130223	2	Alive
5/7/2013 7:04:44 AM														
														Page 1 of 1

The Accession Register report includes these fields:

Columns	Description
Rep Hosp	COC code for the reporting facility of the abstract

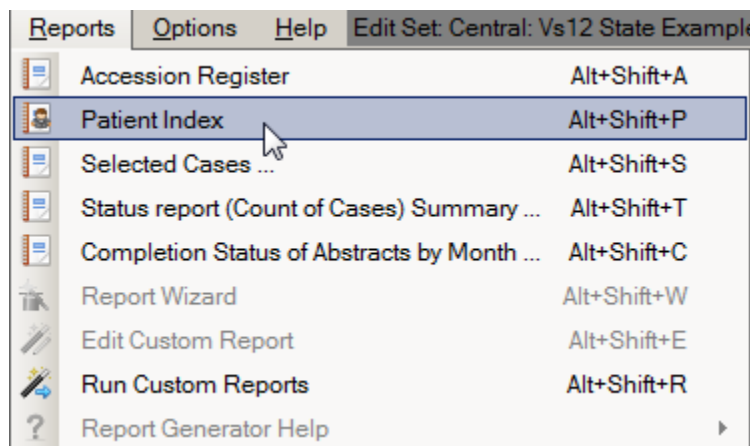
Columns	Description
Acc Num Hosp	Hospital Accession Number for the tumor
Seq	Hospital Sequence Number for the tumor
Name	Name of Patient (Last, First)
Birth Date	Patient's date of birth
Social Security	Patient's social security number
Sex	Patient's sex
Diagnosis Date	Diagnosis date of the tumor
Primary Site	ICD-O-3 topography code describing the location of the tumor
Lateral	Laterality code for the laterality of the tumor
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the tumor
Medical Rec Num	Patient's medical record number
Last Contact	Date of Last Contact with the patient
Abs Ref ID	A unique, system-generated number identifying the abstract
Vital Status	Patient's vital status

- When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Patient Index Report

To run the Patient Index report, complete these steps:

- The Patient Index report can be opened in 2 ways:
 - Click on the **Reports** menu, and select **Patient Index**.



- Use the keystroke **Alt+Shift+P**.

Result: The **Patient Index** report opens in the Report Viewer window. Notice that the abstracts are displayed in alphabetic order by the name.

Patient Index													
Tuesday, May 07, 2013													
Rep Hosp	Acc Num Hosp	Seq Name	Birth Date	Social Security	Sex	Diagnosis Date	Primary Site	Lateral	Hist/Beh ICDO3	Medical Rec Num	Last Contact	Abs Ref ID	Vital Status
0000000001	200101006	02 BRIDE, PRINCESS	19300223	111-11-5009	Male	20010610	C421	0	9760 / 3	9999999	20020131	17	Alive
0000000001	200101006	03 BRIDE, PRINCESS	19300223	111-11-5009	Male	20010623	C779	0	9680 / 3	9999999	20020605	18	Alive
0000000001	200101067	01 DAYS, HAPPY	19351022	111-11-5016	Female	20010522	C504	1	8500 / 3	9999999999	20021117	20	Alive
0000000001	200101067	02 DAYS, HAPPY	19351022	111-11-5016	Female	20010522	C504	1	8211 / 3	9999999999	20021117	21	Alive
1111111111		00 DOE, JOHN	19610316	999-99-9999	Male	20130223	C619	0	8140 / 2	12312312312	20130223	2	Alive
0000000001	200101078	03 DRIVER, CABBY	19330316	111-11-1078	Male	20020401	C182	0	8481 / 3	9999999999	20031212	22	Dead
0000000001	200101078	04 DRIVER, CABBY	19330316	111-11-1078	Male	20020401	C184	0	8481 / 3	9999999999	20031212	23	Dead

The Patient Index report includes these fields:

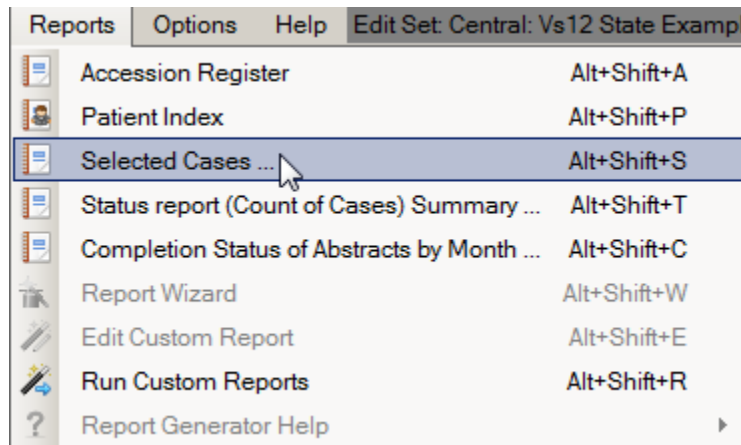
Columns	Description
Rep Hosp	COC code for the reporting facility of the abstract
Acc Num Hosp	Hospital Accession Number for the tumor
Seq	Hospital Sequence Number for the tumor
Name	Name of Patient (Last, First)
Birth Date	Patient's date of birth
Social Security	Patient's social security number
Sex	Patient's sex
Diagnosis Date	Diagnosis date of the tumor
Primary Site	ICD-O-3 topography code describing the location of the tumor
Lateral	Laterality code for the laterality of the tumor
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the tumor
Medical Rec Num	Patient's medical record number
Last Contact	Date of Last Contact with the patient
Abs Ref ID	A unique, system-generated number identifying the abstract
Vital Status	Patient's vital status

- When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Selected Cases Report

To run the Selected Cases report, complete these steps:

1. The Selected Cases report can be opened in 2 ways:
 - a. Click on the **Reports** menu, and select **Selected Cases**.



- b. Use the keystroke **Alt+Shift+S**.

Result: The system displays a window to enter report criteria.

Query Items [Multiple item selection allowed]

☒ All ☐ Complete Abstracts Only ☐ Incomplete Abstracts Only

Item Value

Last Name: DOE First Name: Medical Record #: Social Security #: Example: 12345678901 Example: 123456789

Note: Partial name search allowed

Abstract ID: To: Reporting Hospital: Date of Birth: Example: 1234567890 Example: 12345678901 Example: 2008/12/15 (YYYY/MM/DD)

☒ Select/Deselect All

Query Results: 1 Abstract found.

Report Case	Name	Abstract ID	Date of Birth	Social Security #	Sex	Acc Num Hosp	Seq Num Hosp
<input checked="" type="checkbox"/>	DOE, JOHN	2	1961/03/16	999-99-9999	Male		00

2. Enter report **selection criteria**, and click **Query**. Available report selection criteria include patient last name, first name, medical record number, social security number, date of birth, Abstract Reference ID, reporting hospital, and abstract completion status. In the example shown, the report criterion of Last Name of DOE is being specified.

Result: The system displays the cases that meet the entered criteria in the query result window.

**Tip**

You can further restrict the cases included in the report by un-checking the **Report Case checkbox** in the left-most column of the query window for those cases you would like to exclude from the report.

3. Click **Report**.

Result: The **Selected Cases report** opens in the Report Viewer window. Notice that it displays only the cases that fall within the specified range. The system also records and displays the SQL statement used to create the report at the top of the report.

Selected Cases Tuesday, May 07, 2013															
Selection used to create report:		SELECT NameX, ABSTRACTS.AbsRefID, (Mid(SocSec,1,3) + '/' + Mid(SocSec,4,2) + '/' + Mid(SocSec,6,4)) as SocSec, Switch(Sex = '1','Male',Sex='2','Female',Sex='3','Other (hermaphrodite)',Sex='4','Transsexual',Sex='9','Not Stated/Unknown') AS Sex, AccNumHosp, SeqNumHosp, PSite, RepHosp, Lateral, (HistTypeICDO3 + '/' + BehaviorICDO3) AS HistTypeICDO3, MedRecNum, Switch(VitalStatus = '1','Alive',VitalStatus = '0','Dead',VitalStatus = '') AS VitalStatus, (Mid(BirthDate,1,4) + Mid(BirthDate,5,2) + Mid(BirthDate,7,2)) as BirthDate, (Mid(DxDate,1,4) + Mid(DxDate,5,2) + Mid(DxDate,7,2)) as DxDate, (Mid(Date1stCont,1,4) + Mid(Date1stCont,5,2) + Mid(Date1stCont,7,2)) as Date1stCont, (Mid(DateLastContact,1,4) + Mid(DateLastContact,5,2) + Mid(DateLastContact,7,2)) as DateLastContact FROM ABSTRACTS WHERE LastName LIKE "DOE%" ORDER BY NAMEX													
Rep Hosp	Acc Num Hosp	Seq	Name	Birth Date	Social Security	Sex	Diagnosis Date	Date 1st Contact	Primary Site	Lat	Hist/Beh ICDO3	Medical Rec Num	Last Contact	Abs RefID	Vital Status
111111111		00	DOE, JOHN	19610316	999-99-9999	Male	20130223	20130215	C619	0	8140 / 2	12312312312	20130223	2	Alive

The Selected Cases report includes these fields:

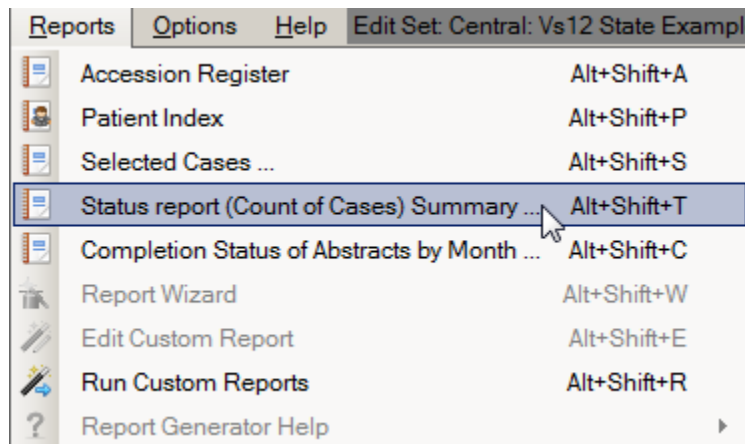
Columns	Description
Rep Hosp	COC code for the reporting facility of the abstract
Acc Num Hosp	Hospital Accession Number for the tumor
Seq	Hospital Sequence Number for the tumor
Name	Name of Patient (Last, First)
Birth Date	Patient's date of birth
Social Security	Patient's social security number
Sex	Patient's sex
Diagnosis Date	Diagnosis date of the tumor
Date 1 st Contact	Date of first contact with the patient
Primary Site	ICD-O-3 topography code describing the location of the tumor
Lateral	Laterality code for the laterality of the tumor
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the tumor
Medical Rec Num	Patient's medical record number
Last Contact	Date of Last Contact with the patient
AbsRefID	A unique, system-generated number identifying the abstract
Vital Status	Patient's vital status

4. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Status Report (Count of Cases) Summary

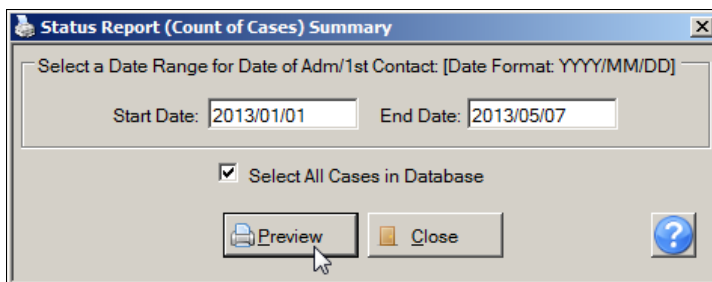
To run the Status Report (Count of Cases) Summary report, complete these steps:

1. Status Report (Count of Cases) Summary report can be opened in 2 ways:
 - a. Click on the **Reports** menu, and select **Status report (Count of Cases) Summary**.



- b. Use the keystroke **Alt+Shift+T**.

Result: The system displays a window where you enter a date range, or select all cases in the database for the report.



2. Enter the desired **date range**, or check the Select All Cases in Database check box to include all abstracts in the database, and click **Preview**. In the example shown all abstracts in the database are being included in the report.

Result: The **Status Report (Count of Cases) Summary report** opens in the Report Viewer window displays the summary information for the abstracts.

Status Report (Count of Cases) Summary (All Cases in Database)			
	Exported	Unexported	Total
Number Complete	0	0	0
Number Incomplete	0	17	17
Grand Total	0	17	17

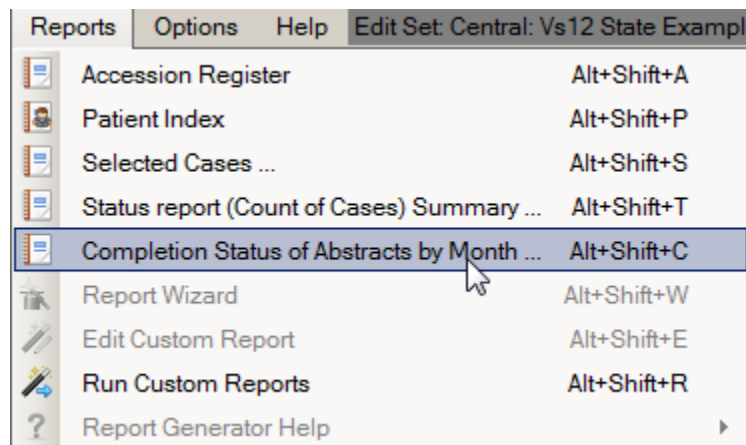
The Status Report (Count of Cases) Summary report includes the number of incomplete and complete abstracts, stratified by abstract export status.

- When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Completion Status of Abstracts by Month

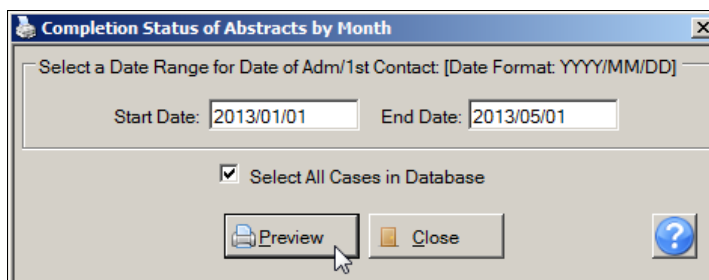
To run the Completion Status of Abstracts by Month report, complete these steps:

- The Completion Status of Abstracts by Month report can be opened in 2 ways:
 - Click on the **Reports** menu, and select **Completion Status of Abstracts by Month**.



- Use the keystroke **Alt+Shift+C**.

Result: The system displays a window where you enter a date range, or select all cases in the database for the report.



2. Enter the desired **date range**, or check the Select All Cases in Database check box to include all abstracts in the database, and click **Preview**. In the example shown all abstracts in the database are being included in the report.

Result: The **Completion Status of Abstracts by Month** report opens in the Report Viewer window displays the summary information for the abstracts.

Completion Status of Abstracts by Month (All Cases in Database) Tuesday, May 07, 2013				
Year	Month	Completed	Incomplete	Total
2001				
	May	4	0	4
	June	2	0	2
	July	1	0	1
	August	2	0	2
	Total	9	0	9
2002				
	April	2	0	2
	September	1	0	1
	Total	3	0	3
2013				
	February	1	0	1
	Total	1	0	1
<hr/>				
	Grand Total	13	0	13

The Completion Status of Abstracts by Month report includes the number of incomplete and complete abstracts, stratified by diagnosis month and or year.

3. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

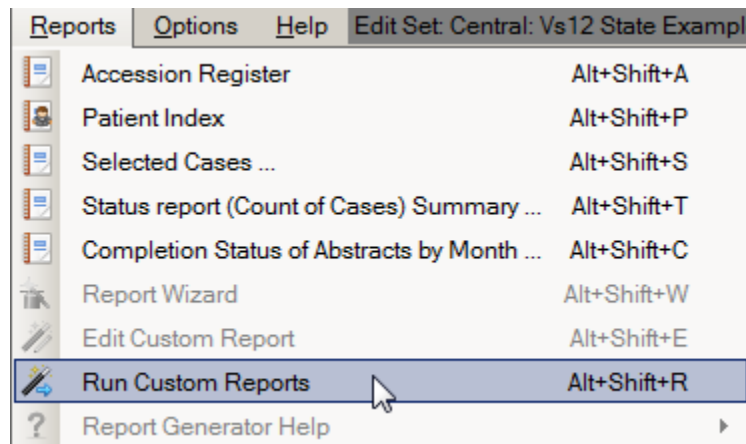
Running Custom Reports

Abstract Plus offers a custom reports feature. This feature is being implemented in phases. In the first release, custom reports that have been generated by the Abstract Plus Development team at CDC can be opened by Abstract Plus users. The various other custom report features, such as being able to generate your own report or modify an existing one, will be implemented in future versions of Abstract Plus.

To open and view a custom report, complete these steps:

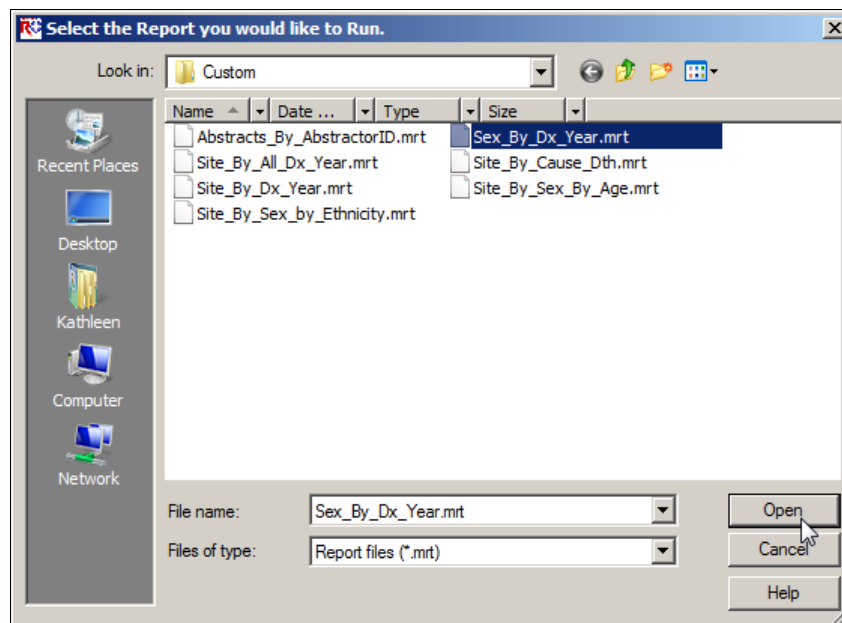
1. The custom report can be opened in 2 ways:

- a. Click on the **Reports** menu, and select **Run Custom Reports**.



- b. Use the keystroke **Alt+Shift+R**.

Result: The **Select the Report you would like to Run** window opens.



2. Select the custom report you would like to open and click **Open**.

Result: The **selected report opens** in the Abstract Plus Report viewer window.

3. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

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Chapter 6: Submission of Data

Learning Objectives

In this chapter, you will learn:

- How to submit an Export file to the Michigan Cancer Surveillance Program (MCSP)

Submission of Data Instructions

After completing the instructions for Exporting Abstracts, submit the Export file to the MCSP using the MCSP File Transfer Protocol (FTP) site, which is the fastest and most secure data transfer for submission of your data. The instructions are as follows.

1. File Transfer Protocol (FTP): To submit Exported Files using the FTP site, follow the instructions listed below.
 - a. Go to DCH application portal at <https://sso.state.mi.us> and login using the SSO userid assigned to you by the MCSP.
 - b. Click on DCH-File Transfer.
 - c. Click on Upload File.
 - d. Click on Browse button and select the directory/path and file name (*Exporting Procedure* step 8)
 - e. The path and file name will show up on the box next to the Browse button.
 - f. Click on Upload.
 - g. Refer to instructions in the MCSP FileXFr User Manual.

NOTE: If you do not have an SSO account, please contact Terry McTaggart at 517/335-9624 or mctaggartT1@michigan.gov, or (517) 335-9624.

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Appendix A: Standard Keyboard Shortcuts

Function	Keyboard Combination
Menus	
File Menu	Alt+ F
Administration Menu	Alt+ M
Utilities Menu	Alt+ U
Reports Menu	Alt+ R
Options Menu	Alt+ O
Help Menu	Alt+ H
Right-Click Menu:	
Search Help / Field Context	F1
Edits Information for current field	F2
Field Message	F3
Special Field Lookup	F4
CS or Age calculations	F5
Run EDITS on current Abstract	F8
Undo text change	Ctrl+ Z
Cut selected text	Ctrl+ X
Copy selected text	Ctrl+ C
Paste text from clipboard	Ctrl+ V
Delete selected text	Alt+ D
Select All text in entry field	Alt+ A
Move to first Text Field	Ctrl+ T
Section Headings	Alt+ S
Display Types	Alt+ T
General	
Open a pull-down data item listing	Alt+ Down Arrow
Move to next field	Enter or Tab
Move to previous field	Shift+Enter or Shift+Tab

Appendix B: Flowchart for Hematopoietic

